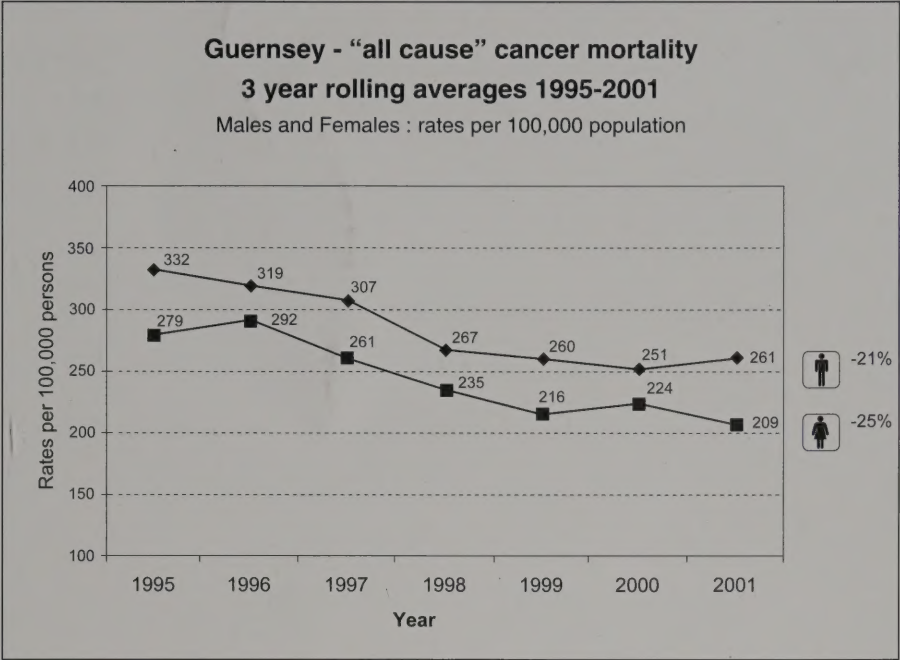
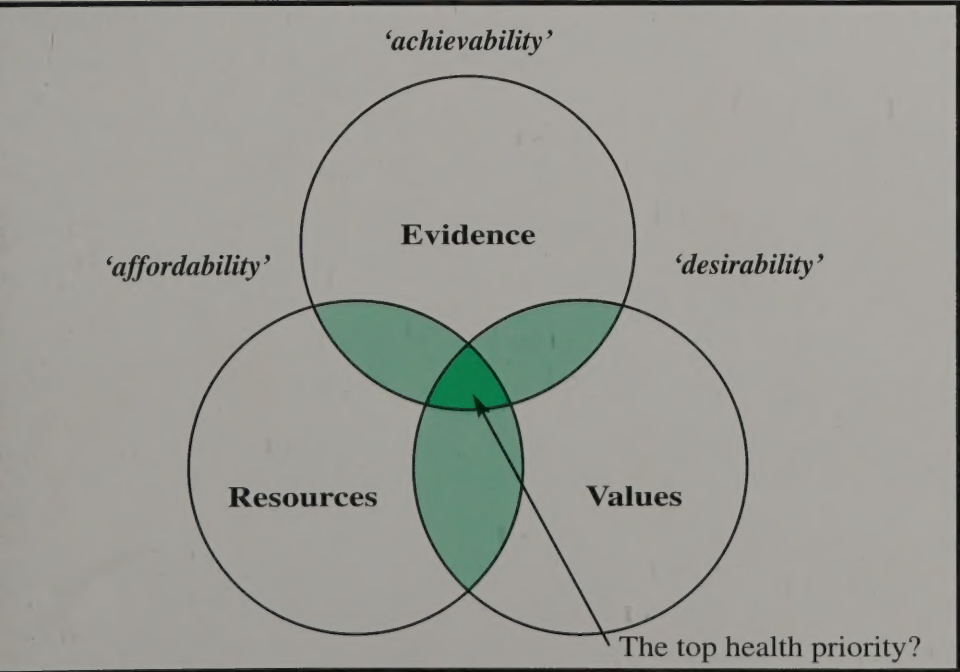




Source: MoH Reports Guernsey 1993-2001

103rd ANNUAL MOH REPORT
EIGHTH ANNUAL DPH REPORT

Special Theme:
*Developing Health
 Strategy for Guernsey*



**REPORT FOR
 THE YEAR 2001/02**



BOARD OF HEALTH

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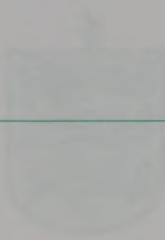
(from June 2001)

Dr C Monkhouse

Front Cover

'Developing Health Strategy in Guernsey'

- 'All cause' cancer mortality continues to improve year by year in Guernsey with over 20% fall in cancer deaths in both sexes over the past seven years.
- Three 'decision drivers' for helping select new health priorities – 'affordability', 'desirability' and evidence-based 'achievability'



STATES OF GUERNSEY

BOARD OF HEALTH

Objectives (as revised)

To maintain and improve the health of the people of Guernsey and Alderney by:

- identifying health needs – now and in the future;
- planning the future provision of health services to meet these needs;
- ensuring provision of these services through direct provision, commissioning or indirect influencing;
- ensuring that the quality of health service provided is high through clinical and corporate governance;
- ensuring that only appropriate care or treatment is given, by comparing with best practice standards and other providers;
- ensuring that care and treatment is effective by monitoring the outcome of such interventions;
- listening to the customers in order to understand their needs and working with others so as to best meet these needs;
- informing people on health matters, promoting a healthy lifestyle and environment;
- acting as a ‘caring neighbour’ and considering the environment for future generations;
- checking that all health services provided are as cost-effective as possible;
- acting as a good employer;
- recruiting, training and developing sufficient health care staff;
- valuing the staff and helping them to meet their needs and aspirations.



**INTRODUCTORY LETTER
TO THE
BOARD OF HEALTH**

October 2002

The President
States of Guernsey Board of Health

Dear Sir,

I have pleasure in submitting the 103rd Annual Report of the Medical Officer of Health for Guernsey for 2001/2002.

Yours faithfully,

Dr David Jeffs
MEDICAL OFFICER OF HEALTH
Director of Public Health

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Acknowledgements:

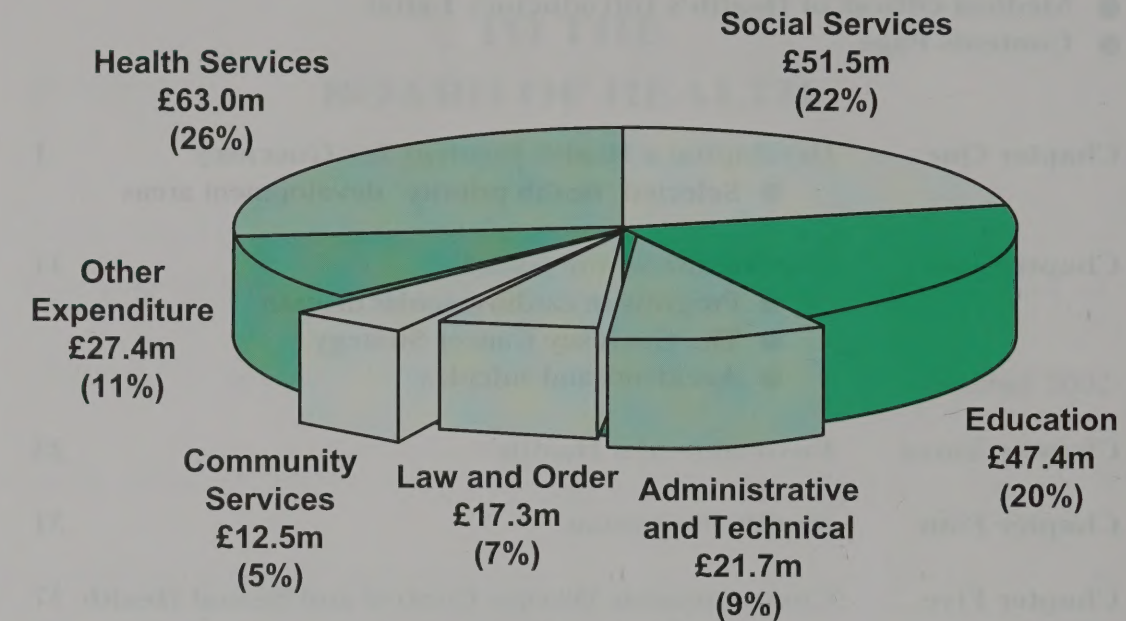
Many people contribute towards the steadily improving health we continue to enjoy in Guernsey and Alderney.

I particularly wish to record my appreciation for the efforts of all Public Health Directorate staff, to others who contribute to public health initiatives, to all the contributors, and especially to my PA Mrs Yvonne Kaill for her efforts in collating this Report, and to Mrs Jenny Elliott who prepared many of the graphs.

Dr David Jeffs
Director of Public Health

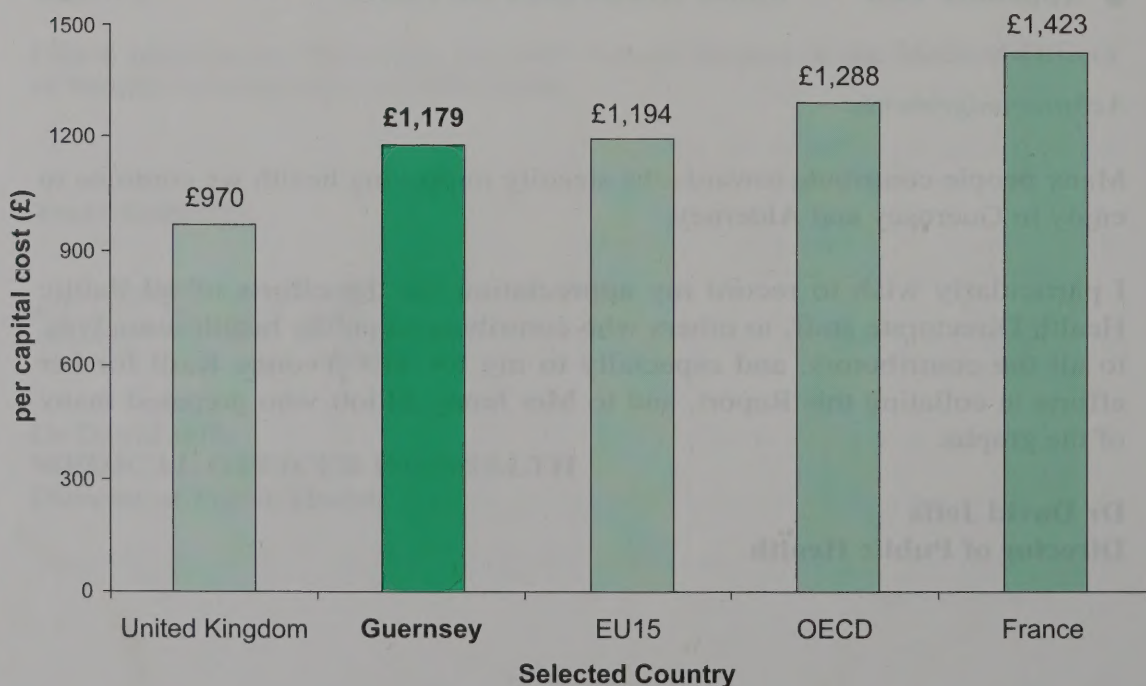


Figure 1.1 - Proposed States revenue expenditure 2003



Total: £240.8m

**Figure 1.2 - Per Capita Cost of Health Care
Guernsey and selected countries 1998**



Source: OECD Health Database 2000

Chapter One

Health Strategy for Guernsey

The 'special theme' for this 103rd Annual MoH Report is '*Developing health strategy for Guernsey*'.

- The Board of Health has a projected revenue budget for 2003 of **£63,294,000** making this the largest single area of States expenditure, ahead of the Guernsey Social Security Authority (GSSA), which has a projected 'formula led' and revenue budget for 2003 of **£55,240,000** (*figure 1.1*).
- The GSSA budget also contains important health care components including the Medical Specialist and Physiotherapy contracts, Pharmaceutical Benefit Scheme, rebates for family practitioner and practice nurse attendances, the Medical Expenses Assistance Scheme (MEAS) and for some off island related travel costs.
- On the 31st December 2001, the Board employed **1,450** full time equivalent staff, making it the largest States employer ahead of the Education Council's **830** FTEs. Approximately 80% of all healthcare expenditure is spent on staff costs.
- According to the 2002 *Policy and Resource Planning Report*, the Board has enjoyed over **40%** increase in revenue allocation since 1999, when its budget was only £45,000,000. During the same period, the GSSA has seen an increase in revenue and formula led costs (many of which are health related) of around **30%**.
- Guernsey is not alone in experiencing such pressure on healthcare costs. Although Guernsey spent some **22%** more *per capita* on combined public and private sector health care costs than the United Kingdom in 1998 (the most recent year for which comparative costs are available), it still spends less than the average for all fifteen EU countries and some **17%** less than our nearest continental neighbour, France (*figure 2*).
- The World Health Report in 2000 suggests that in terms of equity, accessibility and health outcomes, France has the most effective healthcare system in the world.

Reasons for rapidly increasing healthcare costs in Guernsey include:

● increasing population

There has been **2%** increase in recorded population between the 1996 and 2001 *Census*.

● ageing population

The number of Guernsey residents aged over 75 years will increase by approximately 30% over the next ten years. People aged over 80 years 'consume' approximately four times more healthcare resources than those of working age.



● **changing epidemiology**

The reasons why people become ill are also changing. Acute diseases such as acute infections and heart attacks are becoming much less common, whereas chronic diseases, which require ongoing care, such as cancer, diabetes and heart failure, are becoming much more common, especially amongst the older population.

● **changing technology**

New technology such as keyhole surgery and improving chemotherapy for cancer means that many people can now be treated as '*day only*' patients and may not need to be admitted to hospital for treatment, or may have considerably reduced lengths of stay.

However, this does not necessarily lead to proportionate reductions in healthcare costs since a disproportionate percentage of these relate to the first day of admission, whilst increased lengths of survival lead to greater ongoing costs.

● **medical inflation**

New drugs and new technologies need to recoup their research and development costs during the lifetime of their patent. At 9%, 'medical inflation' is running at around three times that of general inflation.

● **increased expectations**

The '*latest breakthrough*' story forms a popular topic for both television and newspaper journalism, whilst increasingly patients are turning to the internet for information and presenting to their doctors with what they believe is their desired treatment. Such treatments may not always be the most appropriate or cost effective.

Additionally in an increasingly consumer orientated society, perceived excessive waiting time for treatment are no longer acceptable. For most treatments there will be a target of no more than eight weeks under the new Medical Specialist Group Contract. However, shorter waiting times require additional staff and other resources if such targets are to be met.

Need for a health strategy for Guernsey:

A well developed health strategy is essential for Guernsey if:

- the health needs of the population are to be best met;
- the increasing healthcare budget is to be spent in the most effective way;
- priority areas are to be addressed ahead of those of less urgent need;
- quality of healthcare locally is to be compared against validated external standards.

Health planning in the past

The healthcare system (like many other branches of government) does not start with a 'clean sheet'. In a rapidly changing and evolving healthcare environment, health authorities must make best use of the buildings, personnel and skills they inherit. For example:

- The **King Edward VII Hospital** was opened as the '*States Sanatorium*' in 1903 to treat the then prevalent tuberculosis and other communicable diseases. It is now used for care of older people.
- The **Castel Hospital** was originally built as the '*Country Hospital*' to provide 'workhouse' type accommodation for the mentally ill, mentally handicapped, destitute and elderly of the country parishes. Following service as the 'Emergency Hospital' during the German Occupation, it reverted to the care of the mentally ill in the post war years. It will shortly be replaced by purpose designed accommodation at *La Corbinerie*.
- **Surgical skills** - the attachment of specialist surgeons to particular group practices led to a perception that their specialist skills would not be equally available to all island residents. The outcome of political pressure was the formation of the Medical Specialist Group in 1992.
- **Health Insurance Scheme** - the 1991 *Guernsey Census* suggested that up to 20% of islanders might find cost a barrier to accessing specialist healthcare. This prompted the States to agree to the 1996 Specialist Health Insurance Scheme, leading to secondary healthcare 'free at the point of delivery' for most island residents. The contract with the Medical Specialist Group was renegotiated for a new 15 year term in April 2002.

Service Planning Teams

Healthcare development was thus perceived to be largely reactive, i.e. a problem would be allowed to develop, then a solution devised - often several years in arrears.

To better address this, in 1995 the Board of Health set up a number of Service Planning Teams to advise on and develop priorities in mental health, maternal and child health, services for older people, acute medical and surgical services, learning disability services, physical and sensory disability services and public health.

- The concept was that each 'Service Planning Team' would develop direction, objectives and strategy in its own area. The service directors would then advise on necessary reconfiguration of resources to meet these objectives. At a later stage, all resource requests were ranked by the then Executive Team through a process of '*decision conferencing*'.
- The '*decision conferencing*' process would generate a 'long list' which would form the basis of the submission to the Advisory and Finance Committee through the '*Policy & Resource Planning*' process.
- From this, a number of 'short lists' would be developed under various possible scenarios, e.g.:
 - no overall growth funding;
 - no capital growth funding;
 - no increase in staff numbers, etc.



The need for new approaches

Although obviously superior to *'wait until a problem develops'*, the 'Service Planning Team' approach was found to have a number of weaknesses. These included:

- the variable availability and use of quantitative health data amongst the teams;
- adequate consultation with clients and other stakeholders was frequently lacking;
- service planning teams often took a more narrow *'service development'* perspective, rather than a broader one of *'improvement in health outcomes'*;
- there was little progress in developing an overall *'health strategy for Guernsey'* or *'joined-up services'* across directorates;
- there was little attempt to use *'health evidence'* of what actually works and what offered best value for money - rather an apparent acceptance that *'more must be better'*, whether in terms of money, or of human and other resources;
- the whole may perhaps be summarised as a process of *'creeping incrementalism'* rather than a coherent attempt to best meet the health needs of the people of Guernsey and Alderney within (necessarily) limited resource constraints.

The Public Health and Strategy Directorate

The appointment of a new Chief Executive to the Board of Health in December 2000 and consequent management restructuring offered the opportunity to implement a *'population approach'* to future health service development. It was hoped to ensure that:

- existing epidemiology would be used to help determine the true health needs of the population;
- better analysis of health services provided would help modify these needs in line with changing health needs;
- *'best evidence'* of what was of proven effectiveness elsewhere would help guide service developments;
- local health service research would be encouraged where necessary information was lacking;
- the quality of health services provided would be monitored to ensure optimum health outcomes.

As part of this management restructuring, the Public Health Directorate took over responsibility for health strategy, and a new **Health Strategy Unit** was formed.

This brought together the two arms of *health information* (to help determine the health needs of the population and to monitor levels and types of health services provided) and *clinical governance* (responsible for clinical risk management, clinical audit and demonstrating the delivery of high quality and effective health services).

The wider context

It would be foolish for Guernsey's health system to develop in isolation. Although there are many obvious differences, recent developments within the National Health Service in England must be influential. These include;

- The White Paper '*Our Healthier Nation*' (1999) suggesting a three-pronged approach to improving health in England:
 - information for health;
 - setting standards;
 - measuring progress.
- *Modernising Health and Social Services - National Priorities Guidance 2000/03*.

This Department of Health publication chooses priority areas for '*improving health*', '*saving lives*', '*improving services*', '*modernising strategies*' and '*caring for vulnerable people*', and thus offers a useful '*cross reference*' for proposed health service developments in Guernsey.

● National Service Frameworks (NSF)

These set '*national minimum standards*' against which all health authorities and trusts should demonstrate compliance by specified dates. They are all firmly '*evidence based*' and provide a readily available and necessary '*yardstick*' against which to measure the availability and quality of different clinical services in Guernsey.

To date these include:

- | | |
|--|---|
| - Mental Health NSF | September 1999 |
| - 'National Cancer Plan' | March 2000 |
| - Coronary Heart Disease NSF | March 2000 |
| - Older People NSF | April 2001 |
| - Diabetes NSF | (Part I) March 2002
(Part II expected later) |
| - Children Services NSF | (expected Autumn 2002
or later) |
| - Chronic Neurological Disabilities NSF | (in preparation) |

● Clinical evidence

Through the National Service Frameworks, the National Institute for Clinical Excellence (NICE) and structures for clinical governance, the NHS is now firmly committed to implementing '*what works*' in clinical practice. This commitment to evidence based health policy is not necessarily seen in all aspects of NHS development.

● Clinical governance

Alongside the commitment to 'best evidence', there has been a growing commitment to demonstrate quality standards and outcomes in clinical practice through the development of a '*clinical governance*' framework. Since April 2001, all NHS Chief Executives have had a statutory duty to report on clinical standards and outcomes in the same way as they have traditionally reported financial outcomes.



Selecting health priorities for Guernsey

It is obviously not possible to give 'top priority' to all possible health service development. Under the new '*population approach*' to health service development, priorities have been selected on the basis that they are;

- a common cause of death, premature death <75 years, hospitalisation, or a major component of healthcare costs;
- there is a perception shared by health professionals and members of the public that our present services in this area do not meet acceptable standards as defined by the National Service Frameworks, guidance from NICE, the medical Royal Colleges and other professional bodies, etc.
- There is evidence that further investment will produce measurable improvements in health outcomes at an affordable cost.

On this basis the following six areas have been chosen as 'health priority' development areas over the next 7-10 years;

- Cancer services
- Cardiovascular disease
- Mental health
- Services for older people
- Childrens services
- Services for people with a learning disability

These will now be considered in further detail.

Cancer services

- Cancers are the second leading cause of death (**32%**) and the leading cause of premature death (deaths <75 years) in Guernsey.
- A national plan (NHS National Cancer Plan) exists.
- A *Guernsey Cancer Strategy* has been developed by a taskforce of involved clinicians, visiting consultants and others and has now been accepted by the Board (June 2001).
- It is an area of high health expenditure and this is likely to increase because;
 - projected increase in local chemotherapy from 2 to 5 days per week
 - "knock on" costs of chemotherapy, pharmacists' time, etc
 - rapidly escalating costs of Southampton 'off island' services.
- Opportunities exist for better prevention, reduced mortality and improved quality of life in patients through the adoption of a more strategic approach.

Cardiovascular disease

- Leading cause of mortality (**41%**), and second leading cause of premature death in Guernsey.
- A National Service Framework exists.
- Cardiovascular diseases have a high economic impact through early retirement, limitation of daily activities, etc.
- Present services are fragmented, e.g. primary care, St John Ambulance, Princess Elizabeth Hospital, Medical Specialist Group, Guernsey Chest and Heart, etc.
- Opportunities exist for measurable improvements in both morbidity and mortality through a more “joined up” strategy.

Mental health services

- Sound data on the impact of mental health in Guernsey have been lacking in the past. This is now being addressed.
- A National Service Framework exists.
- Past deficiencies have been identified, and the second of two external reviews by the *Health Advisory Service* proposes a way of systematically addressing these.
- The relocation of services to the Oberlands site, the recruitment of two new consultant psychiatrists, the acceptance of the need for “*clinical governance*” and a commitment to a reorientation of services all provide opportunities for change.
- Proposed new mental health legislation is currently being drafted.
- There is a perception shared by some health professionals and members of the public that our mental health services have not been of high quality in the past. A more strategic approach affords the opportunity to address and improve this.

Services for older people

- Persons > 65 are predicted to increase by 45% over the next 40 years, whilst those > 85 are predicted to increase by 60%. Due to the “*compression of morbidity*” effect, there is considerable evidence that the majority of “lifetime healthcare costs” now occur in the 2-3 years before death.
- A National Service Framework on older people exists.
- The appointment of two new specialists with expertise in this area is imminent.
- The GSSA “long term care” package has been accepted by the States, and provides a strategic approach to meeting many of the housing and social needs of older people.



- Average length of stay for Princess Elizabeth Hospital patients >75 years is approximately 30% greater than in the NHS, suggesting a possible degree of ‘delayed discharge’ due to lack of suitable alternatives.
- There is a perception that Guernsey has not kept up with advances in the care of older people. Opportunities exist for a more strategic approach to address this.

Children’s health services

- New management arrangements will help address much of the previous “fragmentation” of children’s health services.
- A National Service Framework is being developed, and is expected to be published in 2002/2003.
- A strategic approach is currently lacking. A recent “blue sky” day suggests approaches for addressing aspects of this.

Services for people with a learning disability

- A UK standard ‘*Valuing People*’ (not an NSF) exists.
- The Board has previously identified this as being a priority area on the basis that many “carers” were aging, and the Board’s responsibilities in this area would accordingly increase in the future.
- A ‘*Planning, Advisory and Co-ordination Team*’ (PACT) has been established and includes service user participation. It will meet to compare present services in Guernsey against those contained in ‘*Valuing People*’ and other external documents, and recommendations will be made on how deficiencies identified locally can be best addressed within a specified timeframe.

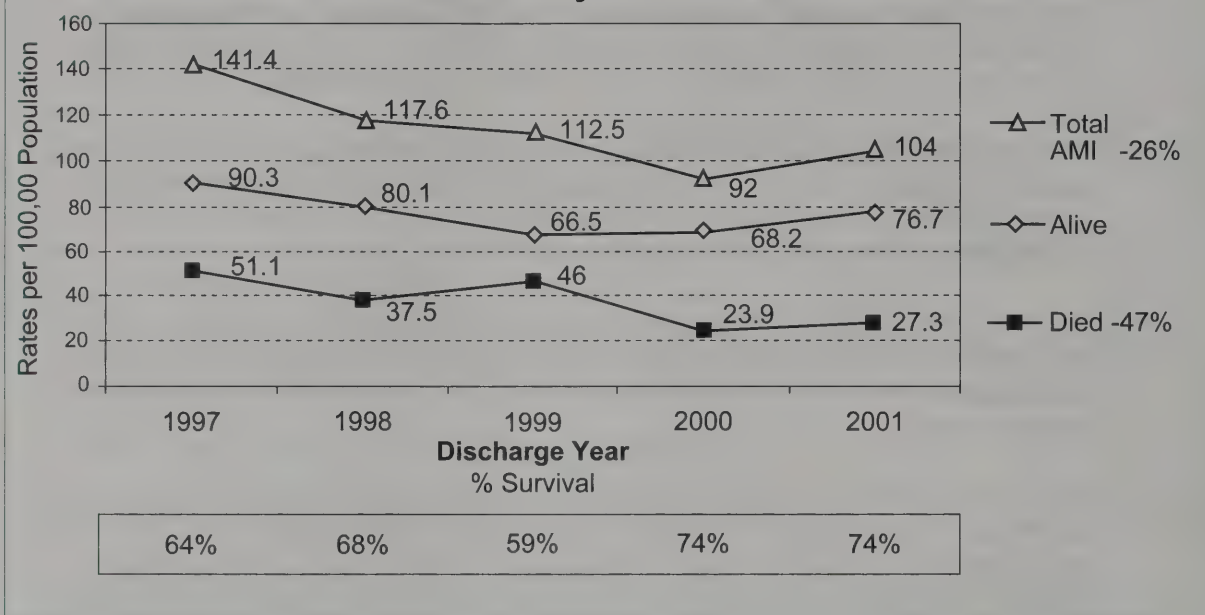
Delivering the Guernsey health strategy

- It is proposed to examine all of the six selected priority areas in a structured way over the next 7-10 years, to identify deficiencies and to systematically address these.
- The ‘*Guernsey Cancer Strategy*’ is seen to be a model for this approach. Here a multidisciplinary group examined present cancer services, compared these with developments proposed in the Calman Hine Report and National Cancer Plan, and specified twenty nine recommendations, which have been accepted by the Board, and are now being progressively implemented.
- Time limited taskforces in the other priority areas have already been established, or shortly will be.
- It is intended to revisit all strategy areas approximately half way through their cycle, depending on the speed of technical and other developments. This will ensure that service development in Guernsey remains responsive to changes in health need, technical progress and other external factors.

- Quality will be an intrinsic part of overall service development. As new services are developed, quality and outcome measures will be specified. These will be monitored, which will in turn influence the further development of these services.
- It is also intended to ensure that the health needs of the population as demonstrated through the *population health strategy* will be central to capital works planning. In the past there has been a tendency for capital planning to be somewhat out of step with strategic planning.
- It is accepted that not all health needs will fall within the six priority areas. A balance needs to be maintained to ensure that the health needs of minority groups are not overlooked, nor the development of 'Cinderella services' unduly hampered.
- However, the same principles of demonstrated health need and evidence of proven effectiveness for proposed interventions should guide the development of such services equally with those within the six selected priority areas.
- Delivery within the six priority areas chosen under the '*population approach*' to health strategy, as well as other '*evidence based*' developments will constitute an ongoing feature of future Medical Officer of Health reports over the next 7-10 years. A start is made in Chapter Two of this Report.

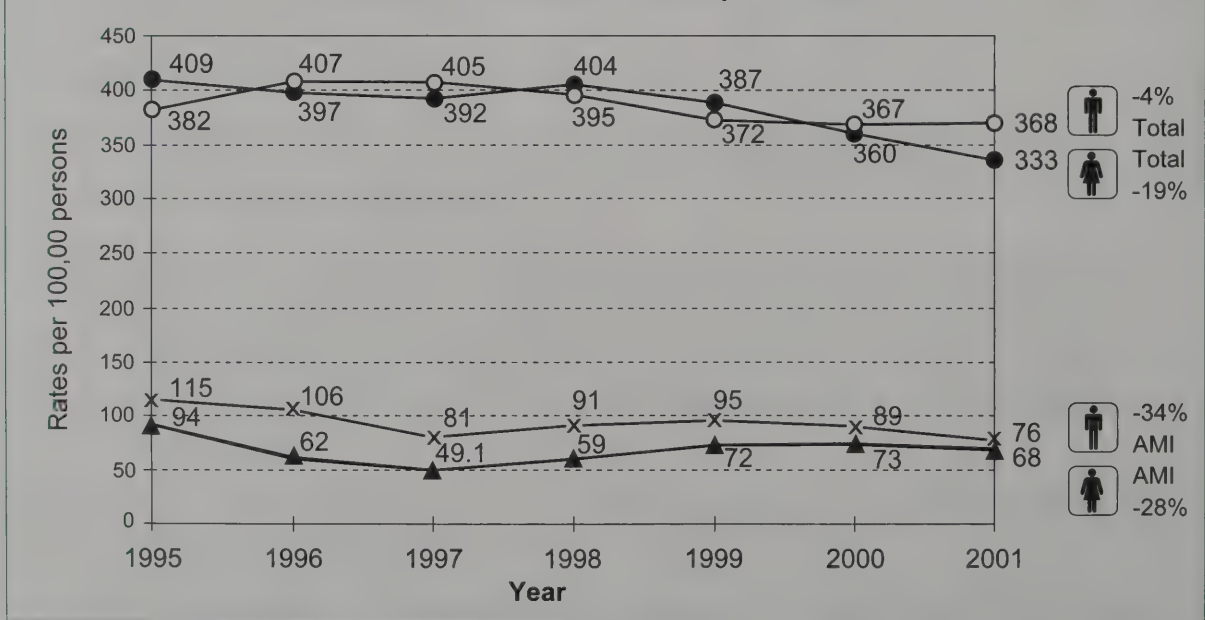


Figure 2.1 - Acute Myocardial Infarction
Discharge Rate and % Survival
Guernsey 1997-2001



Source: Healthcare Information Department, Princess Elizabeth Hospital 2002

Figure 2.2 - AMI and Total Cardiovascular Mortality
3 Year Rolling Averages - Guernsey 1993-2001
Males and Females : rates per 100,000



Source: MoH Reports Guernsey 1993-2000

Chapter Two

‘The health of the islands’

The primary objective of the Board of Health is to *‘maintain and improve the health of the people of Guernsey and Alderney’*.

Under the more strategic approach outlined in Chapter One, a start has already been made on targeting those areas which are the commonest causes of hospital admission, premature death, or where evidence based national standards exist. These include;

Cardiovascular disease

Cardiovascular disease is the single most common cause of death amongst both males and females in Guernsey. In the five years **1996-2000** acute myocardial infarction (AMI) was responsible for **7%** of all male and **6%** of all female deaths, whilst other cardiovascular diseases were responsible for a further **34%** of deaths in both sexes.

● Trends in Acute Myocardial Infarction (AMI) (*figure 2.1*)

Since **1997**, the number of persons admitted to the PEH following acute heart attacks has fallen from 141 to 104 per 100,000 population - a fall of around **26%**. Of those admitted between **1997** and **2001**, overall survival has improved from **64%** to **74%**. Altogether this equates to between **12-15** ‘lives saved’ annually over a five year period.

● AMI and total cardiovascular mortality (*figure 2.2*)

Not all those suffering an AMI will need to be admitted to hospital, and not all those referred to hospital will necessarily survive to be admitted. However, deaths from AMI in the population mirror the downward trend seen amongst hospital patients, with a **34%** reduction amongst males and a **28%** reduction amongst females between **1994** and **2001**.

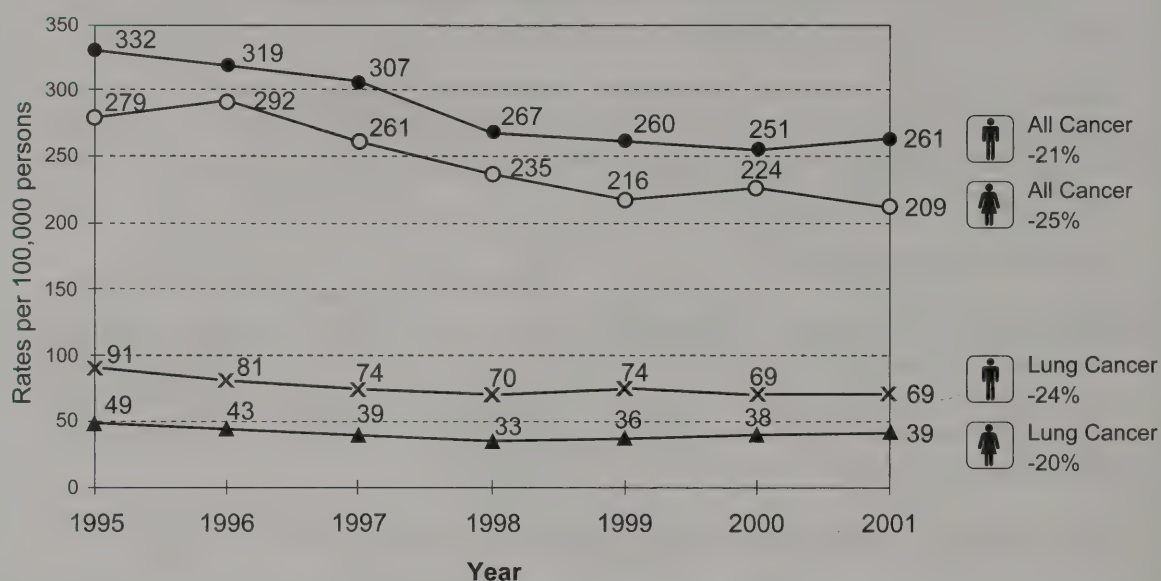
Recent studies would suggest that around **60-65%** of this improvement has been due to better *primary prevention* (i.e. a better understanding of ‘risk factors’ in the community, decreases in smoking levels especially amongst adult males, healthier ‘food choices’, better detection and management of risk factors by primary care practitioners, etc).

The remaining **30-40%** of the improvement is due to better *secondary prevention* i.e. increasing referrals for preventative cardiac surgery (coronary artery bypass, coronary angioplasty, etc), more rapid and expert transport of AMI victims to hospital, better management of AMI in the A&E department, improved outcomes from coronary care unit treatments, increasing referral on update of cardiac rehabilitation.

Despite the impressive falls in deaths from AMI there has been lesser progress in total cardiovascular mortality, with only a **19%** fall amongst males and a **4%** fall amongst females. At least part of this differential is due to the lesser fall in smoking levels amongst Guernsey women.

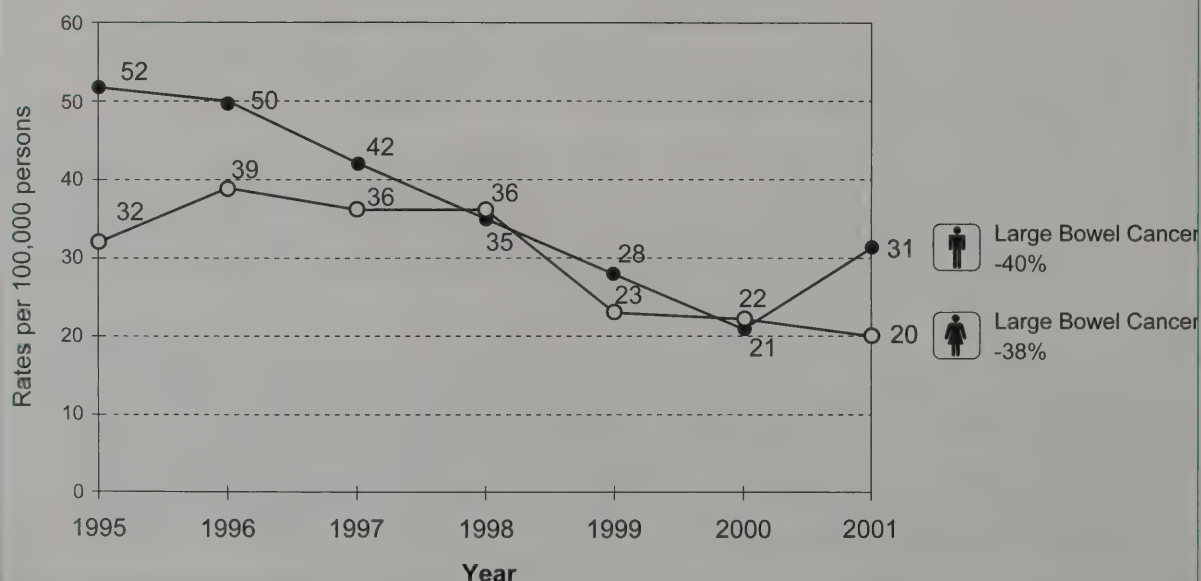


**Figure 2.3 - Total Cancer and Lung Cancer Mortality
3 Year Rolling Averages - Guernsey 1993-2001**
Males and Females : rates per 100,000



Source: MoH Reports Guernsey 1993-2001

**Figure 2.4 - Large Bowel Cancer Mortality
3 Year Rolling Averages - Guernsey 1993-2001**
Males and Females : rates per 100,000



Source: MoH Reports Guernsey 1993-2001

● The National Service Framework for Coronary Heart Disease

The '*National Service Framework for Coronary Heart Disease*' was prepared by an independent expert group led by Professor Sir George Alberti, President of the Royal College of Physicians and published in **March 2000**.

It described itself as '*our blueprint for tackling heart disease it sets out standards and services which should be available throughout England and recognises the importance of modern prevention and primary care, as well as the contribution of more specialist services.*'

The NSF established twelve standards for the prevention, diagnosis, and treatment of coronary heart disease. These standards are intended to remain relevant for ten years or more. Since cardiovascular disease is the single most common cause of death in Guernsey, and a major component of both inpatient treatment costs and total prescribing costs in the community (prescribed cardiac drugs cost **£1.58m** in **2001**), it was considered important to compare levels and management of cardiovascular disease in Guernsey against the standards set out in the NSF.

A multidisciplinary working group consisting of representatives of those professions involved in the prevention, diagnosis, treatment, care and rehabilitation of cardiac patients was formed in **September 2001**, and a final report on coronary heart disease in Guernsey should be completed before the end of **2002**.

This will then be used as a basis for wider consultation with patient groups and the wider community before recommendations are made to the Board of Health on further improving cardiac services in Guernsey.

The need for 'joined up' approaches

● Guernsey Cancer Strategy

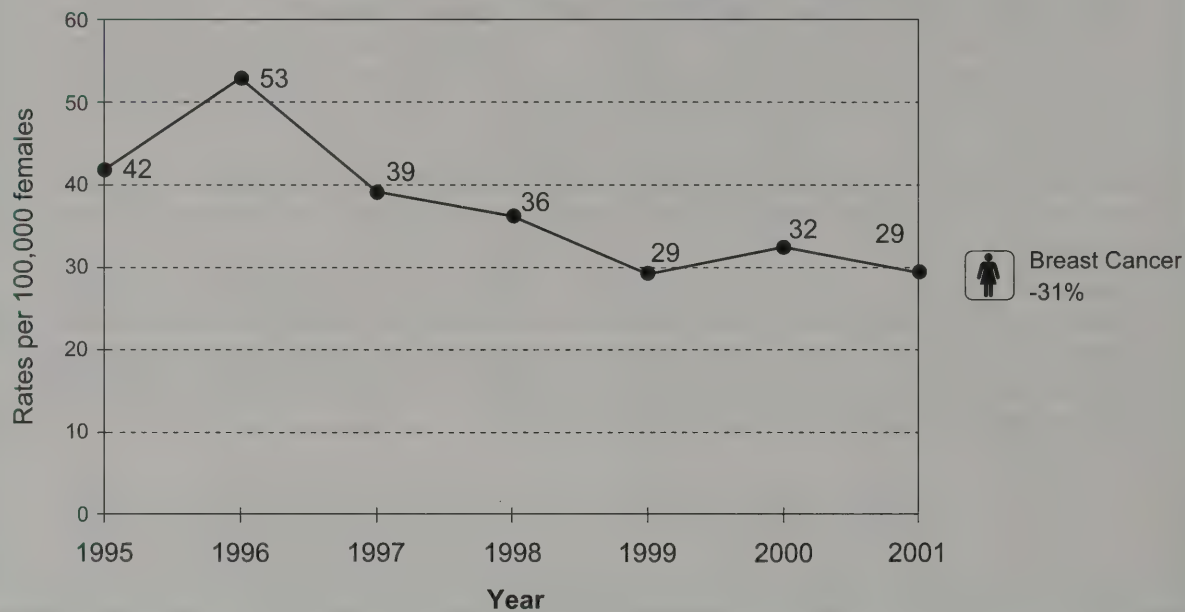
Cancer is the second leading cause of death in Guernsey, responsible for approximately 25% of all deaths. Both the numbers and the overall proportion of cancer deaths are likely to rise over the coming years, not least because of the growing proportion of older people in the population.

The World Health Organisation has recommended that all jurisdictions establish *National Cancer Control Programmes*. To this end a multidisciplinary group was established in Guernsey, and consulted widely before producing a *Guernsey Cancer Strategy* to guide the development of cancer services over the next ten years.

This contained some twenty-nine recommendations, which were accepted by the Board of Health in **June 2001**. These are now being progressively implemented, with an increase in outpatient chemotherapy clinics from 2 to 5 days a week planned, the appointment of two specialist cancer nurses, our involvement in the *Central South Coast Cancer Network*, the appointment of a cancer research nurse with involvement in multi-centre cancer chemotherapy trials, and a greater emphasis on prevention through the appointment of a third Health Promotion Officer who will have special responsibility for cancer control.

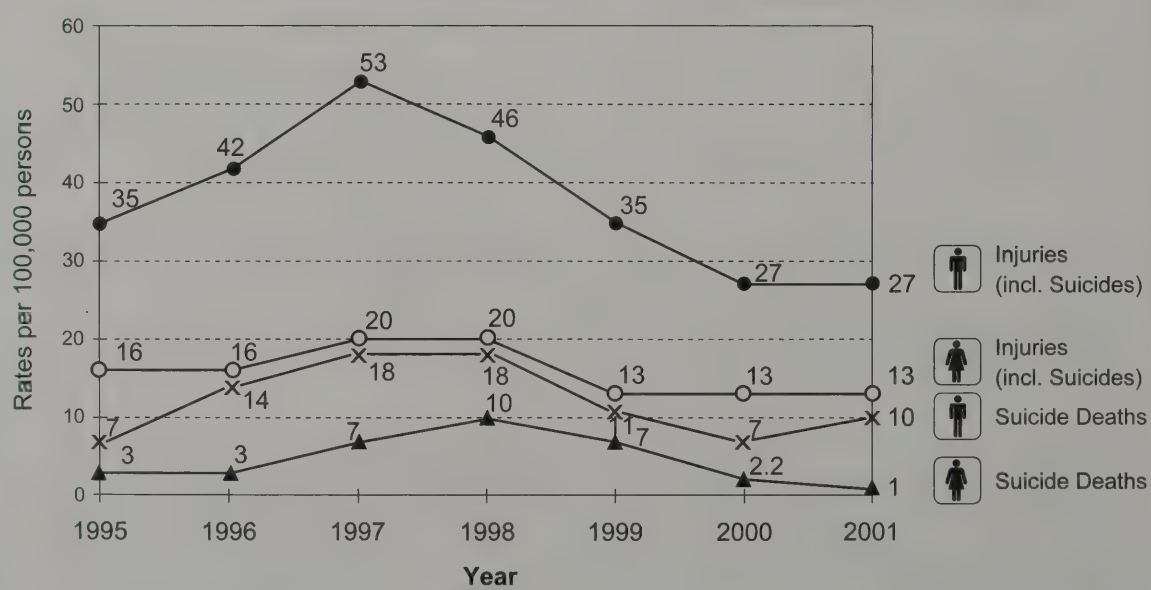


Figure 2.5 - Breast Cancer Mortality
3 Year Rolling Averages - Guernsey 1993-2001
Males and Females : rates per 100,000



Source: MoH Reports Guernsey 1993-2001

Figure 2.6 - Total Injury and Suicide Mortality
3 Year Rolling Averages - Guernsey 1993-2001
Males and Females : rates per 100,000



Source: MoH Reports Guernsey 1993-2001

● Trends in lung cancer and total cancer mortality (*figure 2.3*)

Since 1993 there has been a **24%** fall in lung cancer mortality amongst Guernsey males, and a lesser **20%** fall amongst Guernsey females. According to the most recent Channel Island Cancer Registry report (**2002**), lung cancer is the second most common new cancer amongst men and the third most common new cancer amongst women in Guernsey, comprising **16%** and **10%** of all new cancers respectively.

● Colorectal (large bowel) cancer mortality (*figure 2.4*)

According to the Channel Island Cancer Registry, colorectal cancer is the third most common new cancer amongst Guernsey males and the second most common new cancer amongst Guernsey females, representing **12%** and **11%** of all new cancers respectively.

However, there have been impressive falls in large bowel cancer mortality of **40%** amongst Guernsey males and **38%** amongst Guernsey females since **1993**.

A least part of this improvement must be through earlier detection through our much enhanced flexible endoscopy programme. **840** lower gastrointestinal endoscopies per 100,000 population were performed annually in Guernsey between **1998-2000**, compared with only **230** per 100,000 in England.

● Breast cancer mortality (*figure 2.5*)

The Guernsey breast cancer screening programming commenced in **1992**. Although breast cancer remains the single most common new cancer amongst Guernsey women (representing **27%** of all new cancers between **1997-1999**) there has been an overall **31%** fall in breast cancer mortality since **1993**. **93%** of all women in the target age range of 50-65 years attended for breast screening between **1999** and **2001**, and **27** new cancers (21 of which were invasive) were detected by this means.

Thus part of this improvement in overall breast cancer mortality is due to earlier pick up, part due to better co-ordinated treatment between the specialities involved and part due to the impact of new drugs such *tamoxifen*.

Injury and Suicide Deaths (*figure 2.6*)

Although deaths from injuries and suicides especially are numerically small most years, they contribute disproportionately to '*potential years of life lost*' (*PYLL*). For example, although there were only six suicide deaths in Guernsey during 2001 (compared with three in 2000), five of these were in persons under the age of 45.

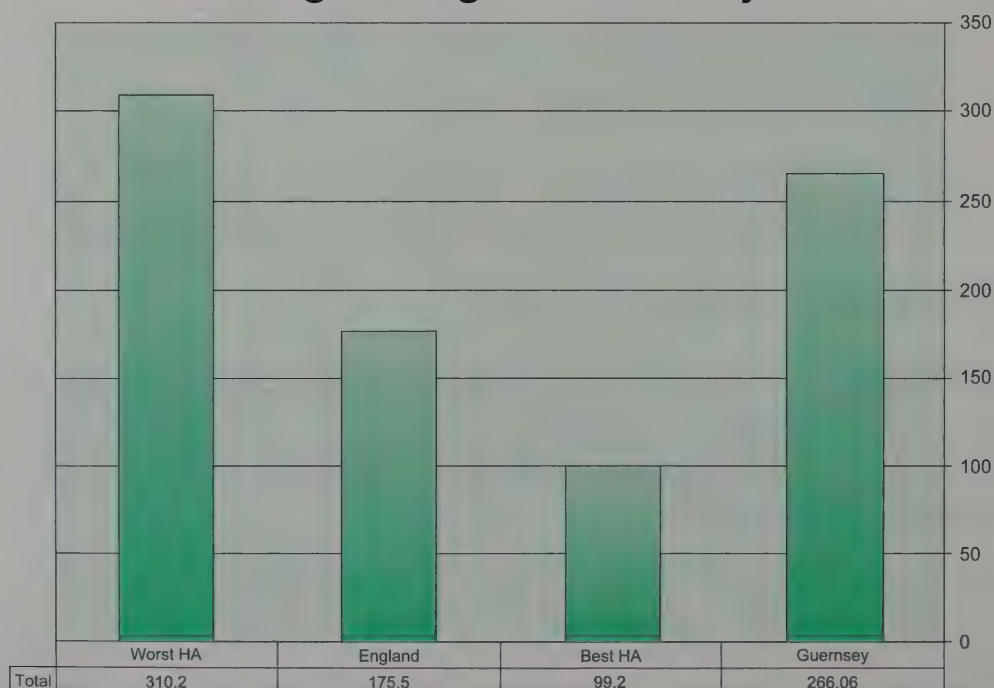
Helping reduce avoidable suicide deaths will be one of the major challenges when a working party to implement the National Service Framework in Mental Health is formed in 2002 or early 2003. A recent publication '*National Suicide Prevention Strategy for England*' reviews some evidence based approaches, which may help reduce avoidable suicide deaths.



**Figure 2.7 - Emergency Admissions:
ENT infection, kidney/urinary tract infection and heart failure
3 Year Rolling Averages - Guernsey 1999-2001***



**Figure 2.8 - Emergency Admissions:
Chronic Asthma and Diabetes
3 Year Rolling Averages - Guernsey 1999-2001***



*Indirectly age standardised emergency admission rate per 100,000 population
Source: Healthcare Information Unit and Department of Health NHS Performance Indicators

Performance indicators and health outcomes

Over the past several years, the NHS has been developing a range of *performance indicators* designed to allow comparisons between different health authorities and NHS Trusts.

Some of these are already incorporated in reporting for hospital ‘league tables’ and indeed the present Chancellor has made demonstrable improvements in performance a precondition for increased levels of NHS funding.

With our improving health information capacity in Guernsey, we are more and more able to compare ourselves against published NHS ‘*performance indicators*’, although we should remember that we are not necessarily comparing ‘*like with like*’, and that demonstrated differences may require further investigation.

● **Primary care management of acute conditions per 100,000 population** (*figure 2.7*)

Effective management of infections of the ear, nose and throat, urinary tract and chronic heart failure should serve to keep patients out of acute hospital beds. Although not performing as well as the ‘best’ health authorities in the NHS, (198 per 100,000 population) Guernsey at 292 per 100,000 is well above the NHS average (370 per 100,000 population).

● **Primary care management of chronic conditions** (*figure 2.8*)

Whereas timely access to a general practitioner, accurate diagnosis and appropriate treatment may prevent an unnecessary acute hospital admission, conditions such as asthma and diabetes need structured and co-ordinated longer term care.

In this, Guernsey appears to do less well, with admission of 266 per 100,000 being well above the average for England (176 per 100,000). Do all these patients really need to come into hospital?

● **Missed outpatient appointments** (*figure 2.9*)

Most outpatient appointments are with the Medical Specialist Group, and these are monitored by the Health Information Unit as part of the Health Insurance contract. ‘*Did Not Arrive*’ (DNA) or ‘failure to keep an appointment’ represents a wasted health resource, in that such an appointment is then not available for other patients. Guernsey patients have a DNA rate of 6.2% of all first appointments, which is better than the ‘best’ health authority in England (6.8%).

● **Emergency admissions** (*figure 2.10*)

A certain proportion of hospital admissions will be genuine emergencies and therefore unavoidable. However, hospitals with high pressure on available beds may find difficulty in admitting patients electively, and will therefore have elevated rates of ‘emergency admissions’. At 66 per 1,000 population emergency admission rates in Guernsey are better than the average for England (79.4) but somewhat above the best health authority (50.7 per 1,000).

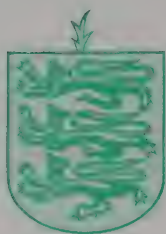


**Figure 2.9 - Missed Outpatient Appointments
3 Year Rolling Averages - Guernsey 1999-2001**

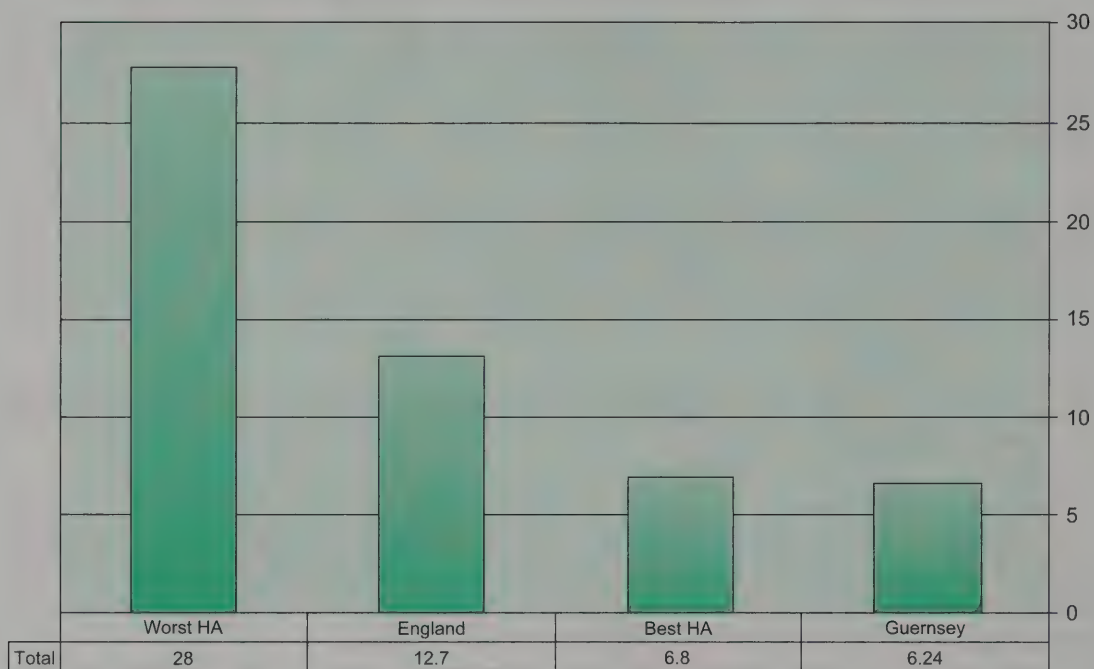
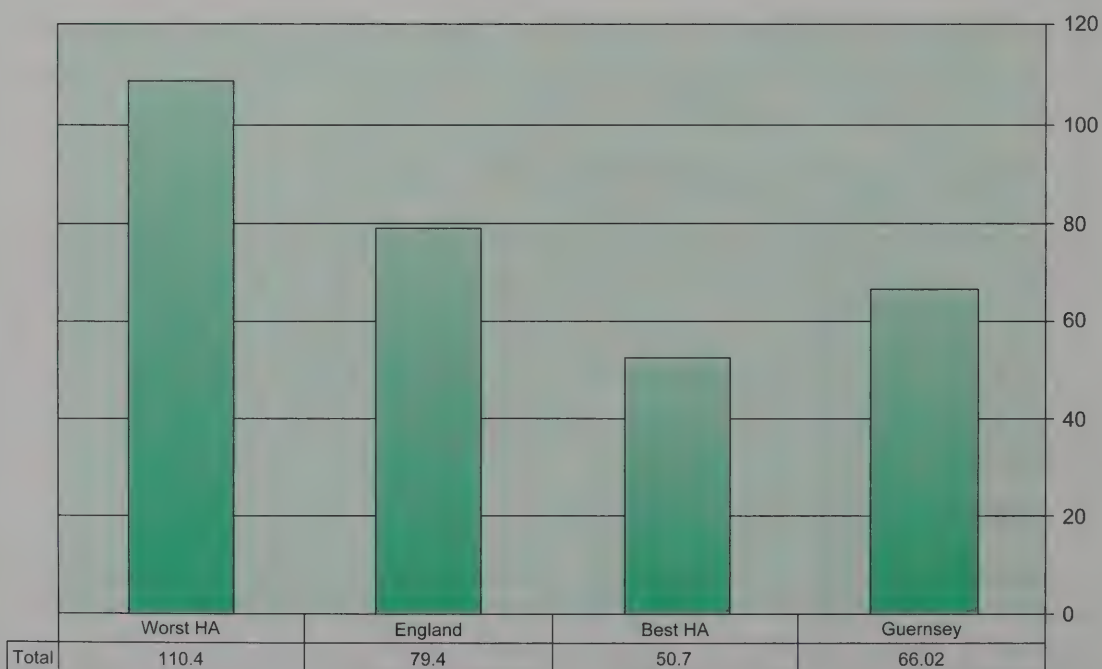


**Figure 2.10 - Emergency Admissions:
3 Year Rolling Averages - Guernsey 1999-2001***



*Number of non-elective General and Acute admissions per 1000 population

Source: Healthcare Information Unit and Department of Health NHS Performance Indicators

Strategic working with others

Although the health of the majority of Guernsey residents continues to improve year on year, addressing the determinants of poor health is not solely the responsibility of the Board of Health.

Across several health areas, particularly those related to reducing the health impact of addictive behaviours, a number of States Committees have partial responsibility within their mandates and a strategic approach is most likely to be successful if it works across traditional committee boundaries.

● Progressing the Guernsey ‘tobacco package’

In July 1996, the States agreed to support a package of measures proposed by the Board of Health to help reduce the **110-120** tobacco related deaths which then occurred every year in Guernsey.

The ‘package’ included a total ban on all public advertising in Guernsey, raising the legal age of purchase from 16 to 18 years, a year on year increase in tobacco excise over a five year period, and enhanced funding to the Health Promotion Unit to allow a range of anti smoking initiatives to be implemented (*Billet d’Etat XII 1996*).

At the end of the five years, a further Policy Letter was taken to the States (*Billet d’Etat VI 2002*) summarising progress which had been made, and proposing further initiatives for the coming five years.

The Policy Letter was able to record a number of successes including an increase in the number of ‘*ex-smokers*’ amongst Guernsey males from **29%** to **40%**, and a somewhat smaller rise in ‘*ex-smoker*’ amongst Guernsey women from **21%** to **24%**.

In addition, annual smoking surveys demonstrate that Guernsey students now take up smoking at a later age than their UK counterparts. In the 2001 survey amongst Year 8 boys only **4%** smoked (compared with **7%** in the UK) and amongst Year 8 girls only **5%** smoked (compared with **10%** in the UK).

These falls in self reported smoking levels are reflected in total tobacco imports into the Bailiwick. These have decreased by **39%** over a ten year period. According to a 1999 ‘*World Bank*’ Report, due to the low ‘*price elasticity*’ of tobacco a 10% rise would be expected to reduce demand by about **4%** fall in ‘high income countries’. Interestingly in Guernsey, an **89%** excise increase since 1990 had led to a **39%** fall in total imports which is broadly in line with these predicted figures.

Using similar methodology, it is possible to show that there has been a fall in tobacco related deaths to **80-85** deaths per year. Although not all such ‘health gain’ is due to the fall in smoking levels, the evidence for part of this is persuasive in that the falls in self reported smoking and smoke related deaths have been greater in men than in women, greater numbers of whom continue to smoke. On this basis, it can be calculated that around **35** people annually (or over **175** Guernsey residents over the past five years) who would have previously have suffered ill health or died from smoking related disease have enjoyed better health and increased longevity because of their reduced smoking.



In April 2002, the States agreed that tobacco excise would continue to rise at above RPI for a further five years, and that there would be further increased funding to help support the range of ‘anti smoking’ initiatives. Progressing our tobacco strategy will involve close working with other States Committees including Education, the Police and the Trading Standards Officers of the Board of Industry. The continuing support of community based groups such as Parents Against Tobacco (PAT), GASP and Guernsey Quitline will also be crucial.

● **The Bailiwick Drug Strategy**

Tackling the growing problems of drug abuse within the Bailiwick requires a joint approach combining;

- *supply reduction* through improved intelligence, interception and enforcement;
- *demand reduction* through better education for all ages;
- *harm minimisation* through more effective treatment and rehabilitation of offenders.

The States accepted the benefits of a more strategic inter-committee approach when they endorsed the Bailiwick’s Drug Strategy in April 2000 (*Billet d’Etat X 2000*). Since then a Drug Strategy Co-ordinator has been appointed, and a Presidents’ ‘Drugs Policy Group’ sets broad policy parameters, whilst a Chief Officers’ Drug Strategy Group meets more regularly to ensure effective co-ordination during implementation.

An early success has been the launch of a ‘Drugs Misuse Database’ which pools information from the various agencies and for the first time can produce a more accurate picture of the size and changing nature of the drugs problem in Guernsey.

It is hoped to appoint a Criminal Justice Drugs Worker in the near future to provide alternatives within the criminal justice system and to improve local treatment and rehabilitation services. It is too soon to say how effective these approaches will be, but at least Guernsey now has the tools to measure, and the co-ordinated action to address a growing social and health concern.

● **Developing an alcohol strategy**

There are many in Guernsey who may consider the health and social damage related to alcohol to be as or more serious than that related to illegal drugs or smoking. In a ‘*health promotion priority setting*’ exercise conducted amongst 65 local ‘opinion leaders’ at the end of 2000, ‘*preventing and treating alcohol abuse*’ was ranked third amongst twenty important health promotion areas.

The development of the Bailiwick Drug Strategy and its subsequent endorsement by the States has provided a model for cross-committee working. An alcohol strategy designed to take a holistic approach to alcohol misuse, and to draw on ‘best practice’ and ‘evidence based’ solutions from elsewhere was therefore proposed along similar lines.

The Board of Health requested the Director of Public Health to convene a working group of Senior Officers from those Committees with responsibilities in this area. The Advisory and Finance Committee agreed to support the appointment of an Alcohol Research Officer on a limited six month contract.

The Working Group met ten times between **June 2001** and **May 2002**, and drew on evidence from a number of 'stakeholders' in this area. A Report on '*The need for a Guernsey Alcohol Strategy*' with a number of recommendations has now been sent to all sponsoring committees.

Following their endorsement, it is hoped to go out to wider community consultation, and if there is sufficient support, both at a political level and more widely amongst the public then it is hoped to incorporate the major recommendations into a policy letter for the States to consider in middle to late 2003.

● Addressing inequalities in health

The association between poverty and poor health has been recognised since at least the time of Hippocrates. The '*Independent Inquiry into Inequalities in Health*' (Sir Donald Acheson 1998), showed that the 'health divide' between the richest and poorest in the UK has widened considerably over the past thirty years. For males the difference in life expectancy between those at the top and bottom of the social scale is now five years (– 75 years compared with 70 years), whilst for women the differential is smaller (80 years compared with 77 years).

During the '*health promotion priority setting*' exercise mentioned above, it was agreed that '*addressing health inequalities*' should be an overriding theme spanning all health promotion activities.

As this Report confirms, health as measured by a range of indices such as infant mortality, cancer deaths, cardiac hospital admissions and deaths, etc continues to improve in Guernsey.

However, we have little or no information about the distribution of health within Guernsey. Traditional measuring tools such on the '*Jarman 8*' index of social deprivation are of limited value when applied to our more homogenous housing mix. Although it would seem intuitively likely, we cannot be sure that findings of the Acheson Report necessarily apply to our smaller island community.

The recent publication of the Guernsey 'Poverty Survey' (May 2002) suggests that up to 18% of the population may suffer '*relative poverty*' and that these are more likely to report poor health.

Additionally, income differentials in Guernsey may be increasing, with one section of the population (including pensioners and the less well paid) experiencing income growth of little above RPI, whilst others enjoy 'average weekly income' growth of at least double this. Over the past five years, RPI has risen by an average of **3.5%** whilst average weekly wages rose by an average of **6.3%** (Source: *Economics and Statistics Unit*). Guernsey is steadily becoming a more unequal society.



Through its Social Policy Working Group, the Advisory and Finance Committee will now examine strategies which may address this relative deprivation and its likely health and social consequences.

There are a number of possible models of 'what works' from elsewhere including the '*Sure Start*' programme for the under fives in England, 'Health Action Zones' and other programmes designed to increase '*social capital*' amongst more deprived sections of the community.

It is hoped that through effective inter-committee working a number of these proven approaches may be successful in addressing the health and social consequences of deprivation in Guernsey.

Chapter Three

Environmental Health

2001 Overview

There were a number of staff changes in the department during the year. In February Mrs. Mhairi Macgregor took up the Environmental Health Officer post vacated by Jonathan Coyde in June 2000. At the end of April, Tobin Cook, who had spent the previous two years at Birmingham University and Birmingham City Council as the department's Trainee Environmental Health Officer, completed his MSc in Environmental Health and passed the professional exams of the Chartered Institute of Environmental Health. At the end of July, Isobelle Belcher returned to the UK after completion of her one-year contract and her post was filled by Tobin Cook.

Simon Penney, the Waste Regulation Officer, left in May to get married and to live and work for the Scotland and Northern Ireland Forum For Environmental Research in Edinburgh. The department was able to appoint Simon Welch from the UK Environment Agency as the Waste Regulation Officer on a five-year contract and he took up the appointment in August.

Finally our office secretary Kelly Moore left in December to have a baby (born December 23rd) and has decided not to return to the department.

Legislative changes

The department continues to work towards implementation of the States' Solid Waste Strategy and the Waste Regulation Officer has been more involved in the process now that some definite decisions concerning the Energy from Waste (EfW) plant have been made. One unforeseen consequence is that the Environmental Health Department may have to operate independently so that compliance with the Human Rights legislation can be achieved. This is expected to become a reality when the *Control of Environmental Pollution (Guernsey) Law* is finally enacted. Delay in the enactment of this Law continued to hamper the effective protection of the Guernsey environment.

Regulations enabling the Department to implement the provisions of the *Tattooing, Piercing, Acupuncture and Electrolysis (Guernsey and Alderney) Law 2000* were passed towards the end of the year and initial registration forms were dispatched to known practitioners before Christmas.



Figure 3.1 Food Safety and Infection Control

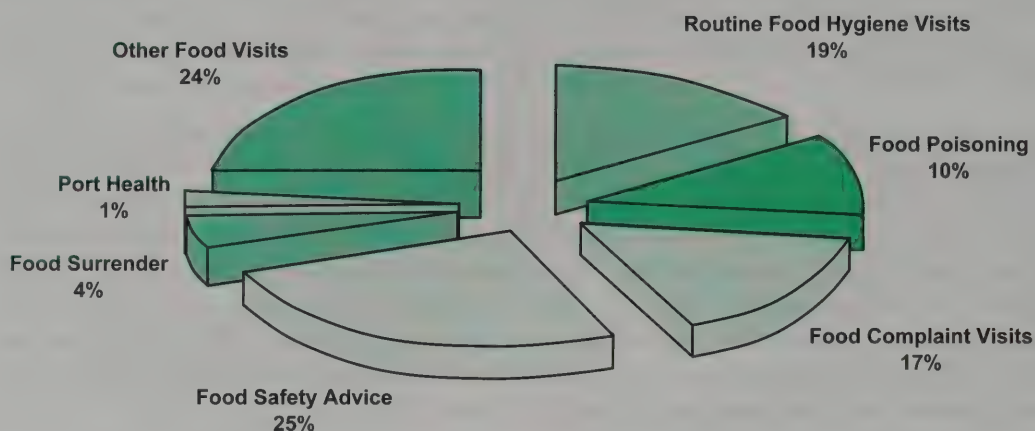
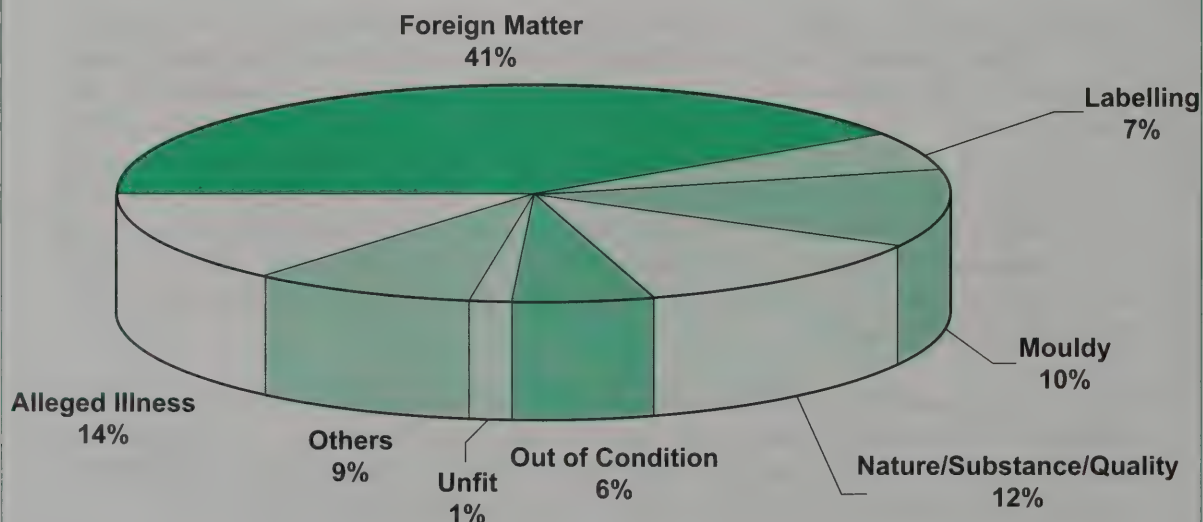


Figure 3.2 Food Complaints 2001 - 69 Complaints



Visits by Department Staff

There are six professionally qualified Environmental Health Officers employed by the department - Chief Environmental Health Officer John Cook, Deputy Chief Environmental Health Officer Tony Rowe and Environmental Health Officers Stuart Wiltshire, Stan Horton, Tobin Cook and Mhairi Macgregor. Officers work in two main sections - **Food Safety and Infection Control**, which deals with all aspects of food control including the inspection of food premises, dealing with complaints about food, promotion and undertaking of food hygiene training and the investigation of the causes of infectious and food-borne disease, and **Environmental Control**, which deals with all matters affecting the environment including housing, noise and air pollution. Routine measurements of environmental parameters, including air quality and seawater, are also undertaken. Waste regulation now forms an increasing part of the section and the department employs a professionally qualified Waste Regulation Officer, Simon Welch. This department also deals with rodent control and employs two rodent control operatives, Paul Tostevin and Michael Brache. The department carried out a total of 6689 visits during 2001 and these are detailed under the section headings.

Food Safety and Infection Control (*Figure 3.1*)

The department continued to promote its Hygiene Award Scheme in 2001, following its successful launch in 1998. The Award Scheme recognises high standards in food hygiene and is divided into three parts - practice and structure, hazard analysis and staff training. In each area emphasis is placed on complying with the legal requirements, recognising good practice and the demonstration of due diligence. More active promotion of the Award by the (now fully staffed) department and greater interest from the trade enabled nine Awards to be made in 2001 compared to the rather disappointing three Awards made in the previous year.

The Food Safety section made 2072 visits during the year 2001. Of these 1088 were initial visits, with 984 being revisits.

Food Complaints (*Figure 3.2*)

A total of 69 food complaints were received during the year, a slight decrease over the 72 recorded in 2000 but the same figure as in 1999.

In 38 of the cases the complaints were either unsubstantiated or the source of the problem occurred subsequent to the purchase of the food. None of the complaints was referred for prosecution.



Figure 3.3 Basic Food Hygiene Certificate Training

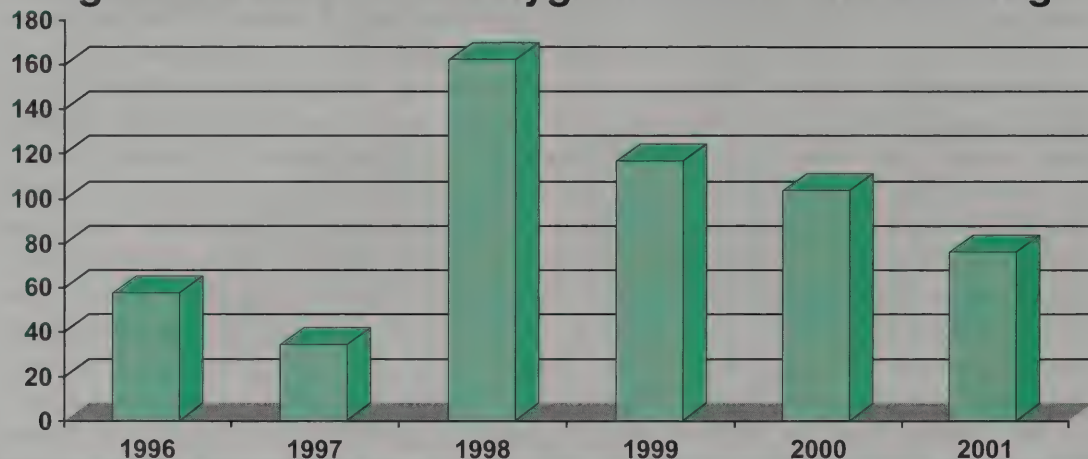


Figure 3.4 Salmonella/Campylobacter Notifications 1995 - 2001

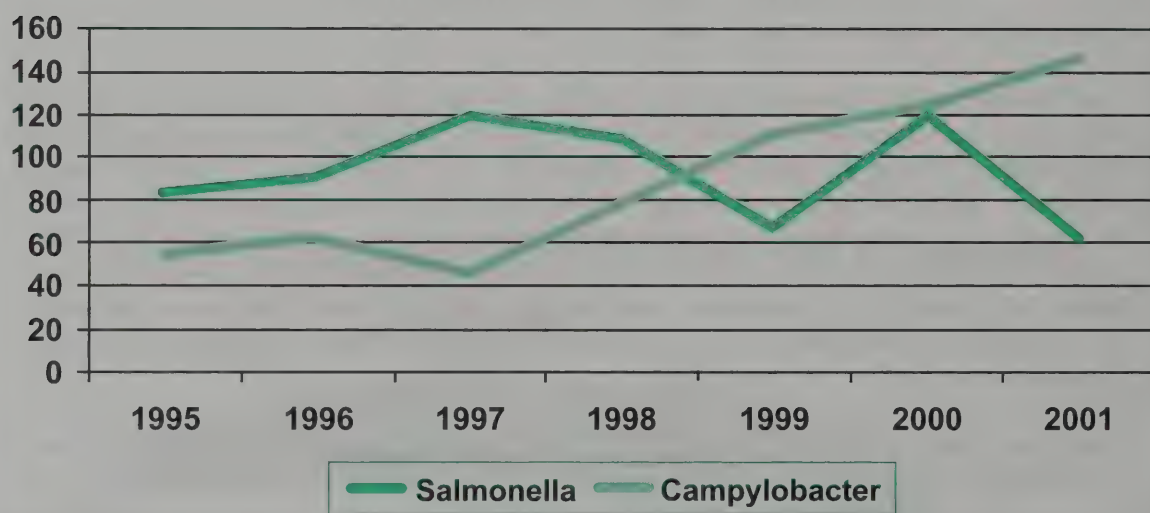
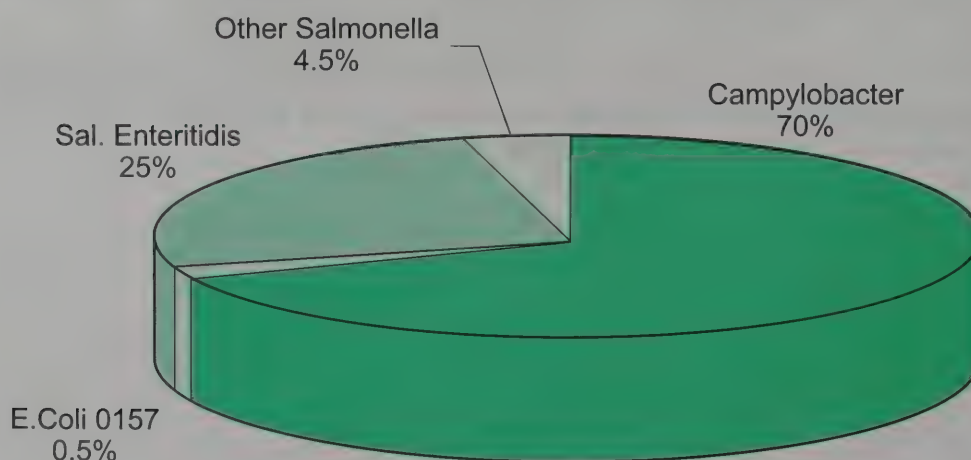


Figure 3.5 Food Poisoning 2001



Food Surrender

A total of 30 surrender certificates were issued during the year. This compares to 27 issued in 2000. The Board's policy of charging for the issue of certificates, freeing valuable officer resources, continues to keep such requests to a minimum and there has been a great reduction from the peak of over 200 in 1992.

Food Hygiene Training (*Figure 3.3*)

The Board's Hygiene Award Scheme has continued to generate interest in the Basic Food Hygiene Certificate.

A total of 10 Basic Food Hygiene courses were run by the department in 2001. Of the 77 candidates, 75 successfully completed the course and were awarded the Certificate. Two Intermediate Food Hygiene Courses were also run during the year with a total of 12 candidates, 9 being successful in the examination and 3 of those obtaining a credit pass.

Formal Action

16 Improvement Notices were served during the year. These involved 4 premises – 2 hotels, one restaurant and one take away food premises. 6 of the notices concerned cleanliness of the premises, 5 related to structural defects and two concerned rodent infestations. The remaining three notices concerned inadequate temperature control due to poor maintenance of refrigerators, lack of suitable hand washing facilities and the use of unsuitable materials for equipment. All improvement notices were complied with although conditions at one of the premises on a further inspection later in the year were again found to be unsatisfactory. This case was referred to the Law Officers for prosecution in October 2001. The outcome was still awaited at the end of the year.

Food Poisoning (*Figures 3.4 and 3.5*)

A total of 62 confirmed cases of salmonella food poisoning were notified to the department during 2001. This figure is a dramatic reduction from the 118 cases seen in 2000. This is the lowest number of cases seen in the last ten years and confirms the downward trend seen over recent years. All were individual cases or family outbreaks and 9 originated outside the Bailiwick. Raw or undercooked eggs were the foods most commonly indicated as the vehicle of infection. One case of *E. coli* 0157 was notified to the department; this was acquired outside of the island. Additionally, there were 147 confirmed cases of *Campylobacter*, which reinforces the recent upward trend in notifications.

Environmental Control (*Figure 3.6*)

Officers made a total of 2256 visits during 2001. 1055 were initial visits with the remainder (1201) being follow up visits.



Figure 3.6 - Environmental Control

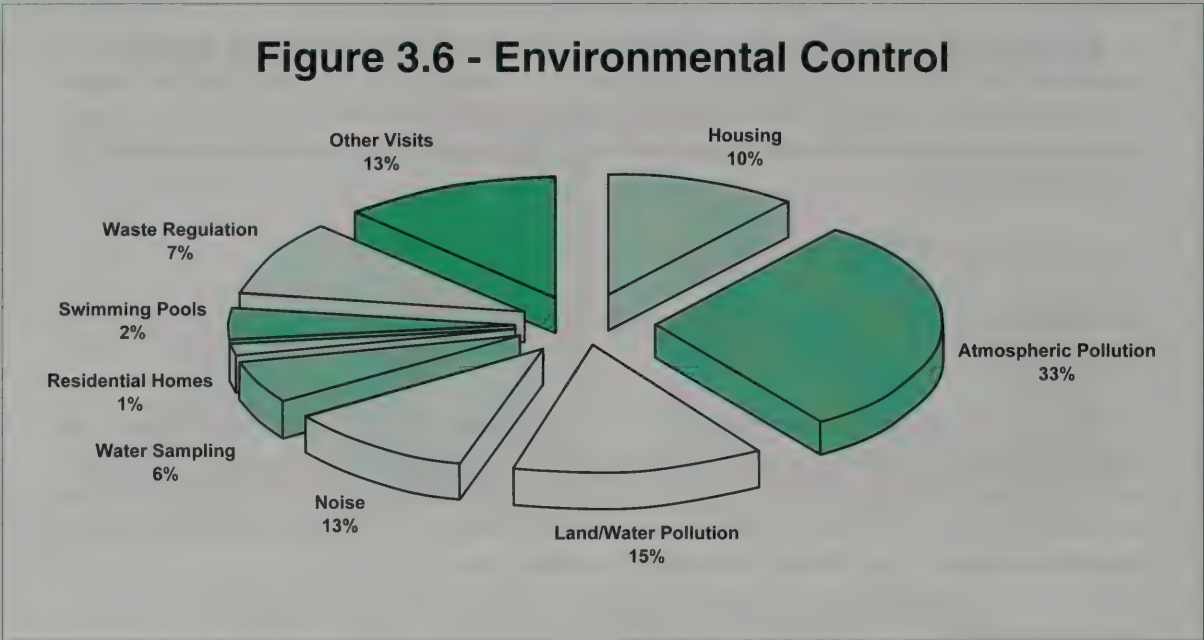
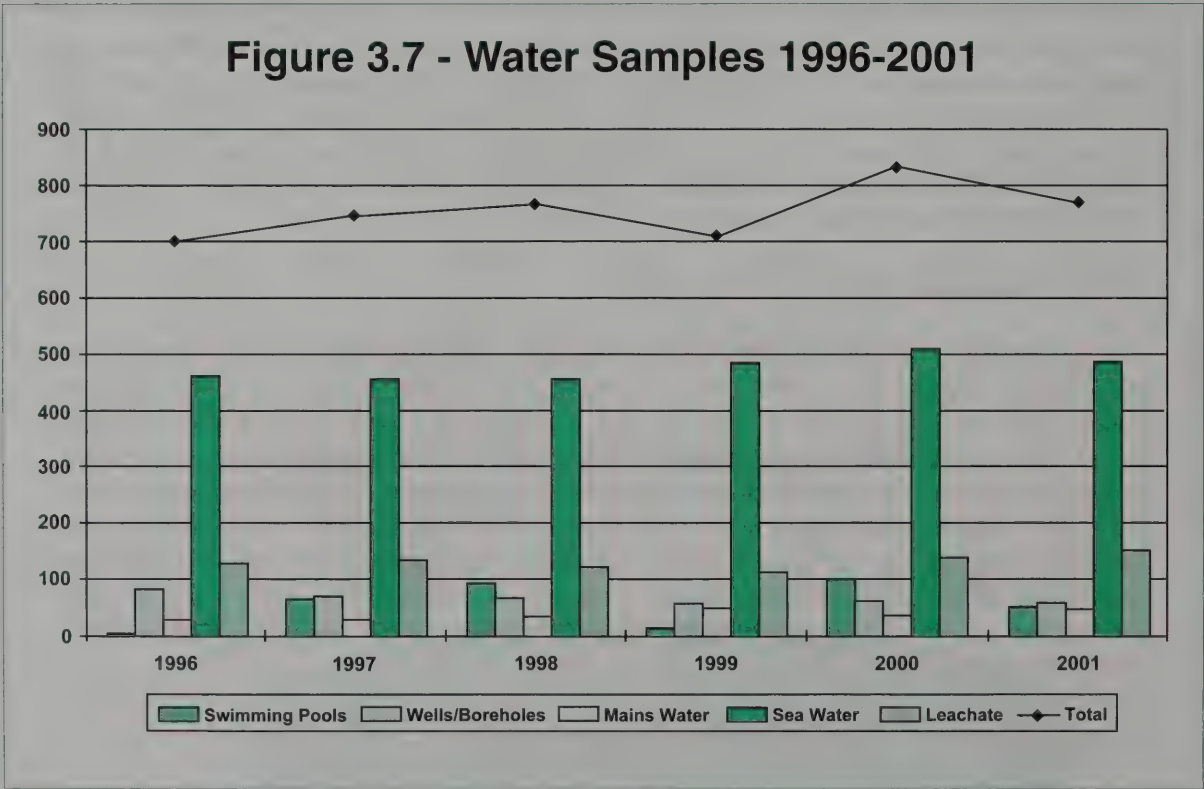


Figure 3.7 - Water Samples 1996-2001



Water Samples (*Figure 3.7*)

The following samples were taken during 2001 for chemical and/or bacteriological analysis.

Water Samples 2001	
Swimming Pools	48
Wells	25
Boreholes	28
Mains Water	45
Sea Water	485
Leachate	147
Other Water Sources	0
Totals	778

Figure 3.7 compares the 2001 sampling programme with previous years' sampling.

Rodent and Pest Control

1254 treatments were carried out including 58 disinfestations. Systematic treatments of bays and headlands have continued throughout 2001. Rodent control operatives carried out 2361 visits in total during the year.

Housing

68 complaints were received during 2001. This resulted in 234 visits to premises to assess housing conditions and to ensure unsatisfactory conditions were remedied. Areas of concern included overcrowding, dampness and unsatisfactory living conditions. The vast majority of the complaints were dealt with by informal action with landlords and it was only necessary to issue one closing notice in respect of units of accommodation unfit for human habitation.

Air Quality

The department's real time air quality monitoring continued throughout 2001. Results indicate that the general air quality of Guernsey remains very good. No exceedances of the relevant guidelines were noted and average levels of the measured pollutants were considerably below the guideline levels.

Nitrogen Dioxide (Roadside)			
Standard	Level in ppb	Maximum Concentration	Date
WHO Health Guideline (1 Hour)	210	65	20 November
WHO Health Guideline (24 Hour)	80	32	13 May

WHO = World Health Organisation



Nitrogen Dioxide (Background)			
Standard	Level in ppb	Maximum Concentration	Date
WHO Health Guideline (1 Hour)	210	43	10 November
WHO Health Guideline (24 Hour)	80	22	11 May

Sulphur Dioxide			
Standard	Level in ppb	Maximum Concentration	Date
WHO Health Guideline (1 Hour)	122	35	19 January
WHO Health Guideline (24 Hour)	100	12	20 January

EPAQS = Expert Panel on Air Quality Standards

Particulates (PM 10)			
Standard	Level in ppb	Maximum Concentration	Date
WHO Health Guideline (24 Hour)	70	48	20 January

The department also continued its monthly nitrogen dioxide survey at nine sites around the island. Despite an increase in the levels measured in College Street, the downward overall trend of previous years continued, with a significant reduction in measured levels in Fountain Street. The fact that both Fountain Street and the Bordage were closed for periods during the year undoubtedly contributed to this reduction.

The UK’s Department of the Environment indicates that levels of nitrogen dioxide below 50 ppb indicate “Very Good” air quality. The results show that, in spite of annual increases in the number of registered vehicles, the standard of air quality in respect of nitrogen dioxide continues to rise and is well within recognised international standards.

Problems with bonfires

I have to say yet again that bonfires of all types continue to be a major cause of complaint to the department. Considerable staff resources are used on dealing with complaints that are, in the main, caused by thoughtlessness and a lack of awareness of alternatives. Although overall air quality continues to improve, indiscriminate burning of unsuitable materials gives rise to very considerable local nuisance. Whilst changes in the public health laws in 1999 made smoke from premises a statutory nuisance, it is difficult to deal with a considerable number of the complaints by formal action. Education and the exercise of consideration for neighbours are necessary to reduce nuisance from this generally unsuitable practice.

Mr John Cook
Chief Environmental Health Officer

Chapter Four

Health Promotion Unit

Introduction

The Unit has had several changes during the last year including recruiting a new secretary who has settled in extremely well. All Unit staff have learnt how to operate the SAP computer ordering and accounting system, and implemented an updated stock control system. The number of resources borrowed has remained constant at **1,840** and the number of posters and leaflets distributed has increased from **66,300** in 2000 - 2001 to **95,224** in the period June 2001 to June 2002. The Resources Officer has been very busy setting up displays to support all the Unit's campaigns as well as creating new leaflets, handouts and materials as required.

The Health Promotion Officers were also involved in leading sessions on general health issues for groups from St Peter Port School, the College of Further Education, Health Visitors and the Institute of Health Studies. They gave presentations at the '6th Inter Island Public Health Forum' in October 2000, Child Health Study Day and an Island Marketing Group meeting, as well as the monthly Civil Service Board and Board of Health staff induction days. The aim of all these sessions was to show how health promotion can be integrated into many settings.

Smoking

The main priority of the Unit continues to be to take the Tobacco Strategy forward. The Assistant Health Promotion Officer therefore devoted a major proportion of her time to working in this area. She ran three smoking cessation training days for health visitors and midwives and two for other health professionals, and further days are planned for the Autumn.

A variety of activities were undertaken to promote *No Smoking Day* including several visits to St Peter Port of "*Craving Man*", a seven-foot high walking cigarette, to highlight the free Zyban and nicotine replacement offers which continued to be offered during the year. The Assistant Health Promotion Officer worked closely with the GASP staff on a number of activities and also to review and revamp their school sessions.

A major project was to plan and then run a peer led training programme for Year 10 students to work with Year 7 pupils. This was successfully piloted at St Peter Port School and there are now plans to take it into other schools next term. Work with Quitline continued to promote the service, including a successful campaign targeting women and tobacco for Europe Against Cancer month in October, and work is in progress to encourage smokers to cut down or to stop before elective surgery. This will be the subject of a 'clinical audit' project.

Alcohol & Drugs

The Health Promotion Officer attended meetings of the officer group working on the development of an island alcohol strategy and continued to promote sensible drinking. She also attended the Island Drugs Strategy Working Group looking at ways to implement its recommendations.



'Live for Life' Programme

The 'Live for Life' programme continued to give the general public the opportunity to learn more about healthy lifestyles and a variety of open sessions were run as well as a series of sessions for a finance house and local church group. Topics chosen were in line with health promotion priorities and included eight-week weight management courses, healthy eating, cancer prevention and the benefits of exercise sessions. Stress management continued to be in great demand with sessions for groups ranging from teachers to nurses, to workplaces and management course students.

As a number of 'Live for Life' tutors have left the programme, or indicated their desire to retire it was decided that a group of new tutors should be recruited. Interviews were therefore held in December and nine tutors from a wide variety of backgrounds undertook the eighty hour training course from January to April.

The course was led by both Health Promotion Officers plus the Assistant Director of Public Health from Jersey and covered all aspects of healthy lifestyles, communication and training skills. These new tutors are currently gathering evidence and being assessed by the Health Promotion Officers to achieve their NVQ Level 3 in Training & Development, which they should finish early next year.

Physical Activity

Closely linked with the prevention of heart disease is the promotion of physical activity and the Assistant Health Promotion Officer worked with a new *Life Fit* Co-ordinator (the exercise on prescription programme at Beau Sejour) to ensure it was meeting the needs of its target group and also to promote the service to medical staff. *The Walk Your Way to Health* programme carried on with a group of hardy participants walking right through the Winter.

Fourteen new walk leaders were recruited and trained in May enabling walks to be set up every week day and these have proved to be very popular with up to fifteen participants at a time. We are very grateful to the volunteer leaders who give up their time, free, each week to enable others to benefit from the exercise and companionship of the group walk.

The Assistant Health Promotion Officer was also part of the steering group to manage the SPORT exercise programme for overweight children and the Health Promotion Officer promoted *Walk to School Week* in the lead up to Guernsey *Car Free Day* in May.

Cancer Prevention

The Assistant Health Promotion Officer worked with the Day Patient Unit to hold a very successful open day on bowel cancer in June 2002 and also assisted in the setting up of the new group - *The Guernsey Bowel Cancer Awareness Charity*. Publicity was given to the prevention of mouth cancer and sponsorship from a local trust enabled the Health Promotion Officers to run a training day for Primary teachers on cancer prevention in the curriculum. This is now to be repeated in the Autumn and a further day arranged for Secondary school staff.

Health Promotion Action



GASP launch their new anti-smoking characters – Wheezer and Geezer – with members of the Breathe Club.

Assistant Health Promotion Officer Gerry (Grange) Le Roy with Sebienn Goman at GASP's fun day for Breathe members, making pizzas!



Year 3 and Year 4 Smokebusters cross country race.



Health Promotion Action

Health Promotion
Officer
Yvonne Le Page
at the start of
Weight Wise month.



Dental surgeon Helen
Frazer examines a
patient, watched by
Quitline advisor
Andrea Tostevin and
dental nurse Laura
Goodall for the launch
of Mouth Cancer
Awareness Week.

Midwife Katie Adams with one week old
James Kennedy for Breast Feeding
Awareness Week.



Heart Disease

The Assistant Health Promotion Officer continued to co-ordinate the Cardiac Rehabilitation programme and work with the *Cardiac Action Group* to ensure a comprehensive service was available for all patients who have suffered a cardiac event, starting whilst still in hospital and continuing at home and in the community. She also attended meetings to implement the National Service Framework in Cardiovascular Disease and was instrumental in setting up a Cardiac Rehabilitation database on computer, which will enable comprehensive statistics to be produced for the first time.

Child Health

Following the success of the first three schools to achieve the *National Healthy School Standard* locally, the Health Promotion Officer worked with the Primary Personal Social & Health Education Co-ordinator to assist two more schools who are working towards the award, including setting up relevant displays and leading sessions for parents. The Health Promotion Officer also supported the Co-ordinator in the setting up and launch of the Primary PSHE Scheme of Work, which was accepted by the Education Council and is to be implemented in all Primary schools. She is currently assisting in the formulation of lesson plans to support the Scheme of Work and in the recruitment of a secondary PSHE Co ordinator to continue the work for children aged 11 to 18.

Meetings of the agencies concerned in teaching health in schools highlighted the need for them to be officially authorised, so the Health Promotion Officer was involved in selecting the criteria and publishing a booklet for all teaching staff outlining the agencies services.

She also continued to chair the Guernsey Child Accident Prevention Group and organised the 7th 'Safety Calling' Challenge at Oakvale School. This was the biggest yet with over 760 Year 6 children attending over eight and a half days and taking part in eight different accident prevention scenarios led by professionals from many different agencies.

The Year Ahead

The next twelve months look to be as exciting as ever with the prospect of the 'Live for Life' programme in full swing once the new tutors have completed their qualifications, and hopefully the appointment of a third Health Promotion Officer. He or she will focus particularly on Cancer Prevention to enable the Unit to fulfil its commitment to the Board's Cancer Strategy.

Yvonne Le Page

Health Promotion Officer

July 2002



Table 5.1
Notification of Communicable Diseases 2001

	<i>1996</i>	<i>1997</i>	<i>1998</i>	<i>1999</i>	<i>2000</i>	<i>2001</i>
Measles	1	0	0	0	0	0
Mumps	0	0	0	0	1	0
Rubella	6	0	0	0	1	0
Whooping Cough	6	0	0	1	5	0
Food Poisoning	160	171	189	237	246	217
Hepatitis A	0	2	0	0	3	3
Hepatitis B	0	2	3	1	2	0
Hepatitis C	1	0	2	0	1	0
Meningitis	4	3	4	0	11	1
Tuberculosis	4	0	3	6	2	5
Malaria	0	0	0	0	0	0
Scarlet Fever	1	0	0	1	0	0
Psittacosis	0	0	0	0	0	0
Dysentery	0	0	0	0	0	0
Q Fever	0	2	1	1	0	0

Chapter Five

Communicable Disease and Sexual Health

Notification of infectious diseases (Table 5.1)

Food poisoning continues to be numerically the most important notifiable infectious disease. The numbers for 2001 were similar to those for previous years. These figures represent the more serious cases, usually notified from the laboratory when specific bacteria causing food poisoning are isolated. We know that many outbreaks are also caused by viruses and do not appear in the statistics.

However, we know that good food hygiene is the key to minimising the food poisoning of all types. This is obviously important for the health of the people of Guernsey and has particular relevance in view of our significant tourist industry. Hotel and restaurant meals have always presented a greater risk than eating at home and the work of the Environmental Health Department is crucial in tracing outbreaks of food poisoning; and more particularly, in preventing them by running courses and offering appropriate advice to hotel and restaurant staff.

Vaccine preventable disease

There were no notified cases of infectious diseases such as polio, tetanus, whooping cough, rubella, measles and mumps that we immunise against in early life. This reflects the successful immunisation policy against these diseases. Tragically media-fuelled concerns about the safety of mumps, measles and rubella (MMR) vaccine has led to some decline in its up-take. This is despite extensive work into explaining its safety in the hope that we do not reach the tragic situation that has occurred in some countries where a declining MMR immunisation rate has led to outbreaks with some complications and deaths from measles.

There were 5 cases of tuberculosis. However, none of these people were coughing up tuberculosis bacteria when tested and we do not believe that they posed any risk to other islanders. Despite investigating all cases, we have identified no evidence of spread.

Due to the success of the childhood immunisation campaign, there was only one case of meningitis. The one case was in an adult who would not have received immunisation and had a particular predisposing cause. The decline in meningococcal septicaemia and meningitis is a tribute to the success of the immunisation policy and now that the supplies of vaccine are adequate, young adults up to the age of 25, who have not previously been immunised against meningococcal C disease are being invited to obtain the immunisation from their surgeries.

Threat of bioterrorism

Sadly, after the events of 11th September 2001, a lot of communicable disease effort has been directed at precautions for possible terrorism using biological agents. In this regard, there has been extensive liaison with the police, fire department and the hospital laboratory to formulate local plans in the unlikely event of a possible bioterrorist attack in Guernsey.



Sexual Health Clinic - KC60 Reporting - Year 2001 (Part A)

Code	Condition		Male Total	of which homosexually acquired	Female Total
A1, A2	Primary and secondary infectious syphilis	1	2	1	0
A3	Early latent syphilis (first 2 years)	2	1		2
A4, A5, A6	Other acquired syphilis	3	0		1
A7	Congenital syphilis, aged under 2	4	1		0
A8	Congenital syphilis, aged 2 or over	5	0		0
A9	Epidemiological treatment of suspected syphilis	6	1		1
B1, B2	Uncomplicated gonorrhoea	7	10	3	4
B3	Gonococcal ophthalmia neonatorum	8	0		0
B4	Epidemiological treatment of suspected gonorrhoea	9	3	1	0
B5	Gonococcal complications	10	0		0
C1, C2, C3	Chancroid / LGV / Donovanosis	11	0		0
C4A, C4C	Uncomplicated chlamydia infection	12	17		13
C4B	Complicated chlamydia infection	13	2		4
C4D	Chlamydia ophthalmia neonatorum	14	0		0
C4E	Epidemiological treatment of suspected chlamydia	15	12		4
C4H	Uncomplicated non-gonococcal / non-specific urethritis in males	16	43		0
C4I	Epidemiological treatment of NSGI	17	2		6
C5	Complicated non-gonococcal / non-specific infection	18	2		1
C6A	Trichomoniasis	19	0		0
C6B	Anaerobic / bacterial vaginosis and male infection	20	0		20
C6C	Other vaginosis / vaginitis / balantis	21	1		2
C7A	Anogenital candidosis	22	10		37
C7B	Epidemiological treatment of C6 and C7	23	0		0
C8, C9	Scabies / pediculosis pubis	24	0		2
C10A	Anogenital herpes simplex – first attack	25	4	4	5
C10B	Anogenital herpes simplex – recurrence	26	6		15
C11A	Anogenital warts – first attack	27	38	10	32
C11B	Anogenital warts – recurrence	28	26	1	20
C11C	Anogenital warts – re-registered cases	29	5		15
C12	Molluscum contagiosum	30	6		4
C13	Antigen positive viral hepatitis B	31	1		0
C14	Other viral hepatitis	32	9		1
D2A	Urinary tract infection	33	2		6
D2B	Other conditions requiring treatment at GUM clinic	34	57		32
D3	Other episodes not requiring treatment	35	139		101
E1A	Asymptomatic HIV infection – first presentation	36	0		0
E1B	Asymptomatic HIV infection – subsequent presentation	37	22	8	8
E2A	HIV infection with symptoms, not AIDS				
	– first presentation	38	2		0
E2B	HIV infection with symptoms, not AIDS				
	– subsequent presentation	39	12	4	0
E3A	AIDS – first presentation	40	2	1	0
E3B	AIDS – subsequent presentation	41	4	4	0
P1A	HIV antibody counselling – with testing	42	191	23	151
P1B	HIV antibody counselling – without testing	43	9	5	13
P2	Hepatitis B vaccination	44	19	9	3
P3	Family Planning	45	0		19
P4A	Cervical cytology – minor abnormality	46	0		7
P4B	Cervical cytology – major abnormality	47	0		2
	Total: all conditions		661	80	531

Sexual Health - 2001

Attendances at the Sexual Health Clinic again increased, with no corresponding increase possible in staffing levels or in the clinic opening times. This reflects a rising demand because of increased disease prevalence, combined with a better understanding and acceptance of the services offered. There appears to be good general awareness of the risks of sexually acquired infection but sadly no corresponding application of this knowledge to help reduce transmission. Broadsheets, tabloids and various magazines frequently run articles on infections such as chlamydia, so inevitably more people become better informed. Increasing infection rates both here and in the UK, however, suggests a failure to follow the 'safer sex' message, with many individuals continuing to enjoy unprotected casual sex.

The figures for chlamydia infection in the year 2001 are not particularly helpful as there is some under-reporting and also a continuing failure to diagnose correctly because of reliance on relatively insensitive ELISA technology. Chlamydia infections are generally asymptomatic in up to 70% of female cases and 50% in male cases. If a high proportion of infected individuals do not seek treatment, then the risks of transmission to partners and of longer term morbidity increases. This longer term includes upper genital infection and its sequelae - pelvic inflammatory disease, chronic pelvic pain, tubal factor infertility and ectopic pregnancy.

The *Sexual Health and HIV* Strategy published by the (English) Department of Health early in 2001 has proposed a national chlamydia screening programme based on recommendations of the Chief Medical Officer's Expert Advisory Group on genital chlamydia infection published in 1998. Before such a programme can be more fully implemented in Guernsey, there needs to be further development of the infrastructure of Sexual Health Clinic, including increases in staffing level and staff training. The benefits of such a screening programme will be lost if there is inadequate contact tracing and follow up. There also needs to be a switch from ELISA based chlamydia diagnostic technology to the more sensitive molecular based technology. It is known that ELISA technology may only be as sensitive as 60%, thus leaving some 40% of cases undiagnosed. Molecular based technology such as PCR and LCR achieves a sensitivity of around 98%. Such a programme will inevitably have cost implications but considerable future savings if consequent reduction in morbidity outweighs these screening costs.

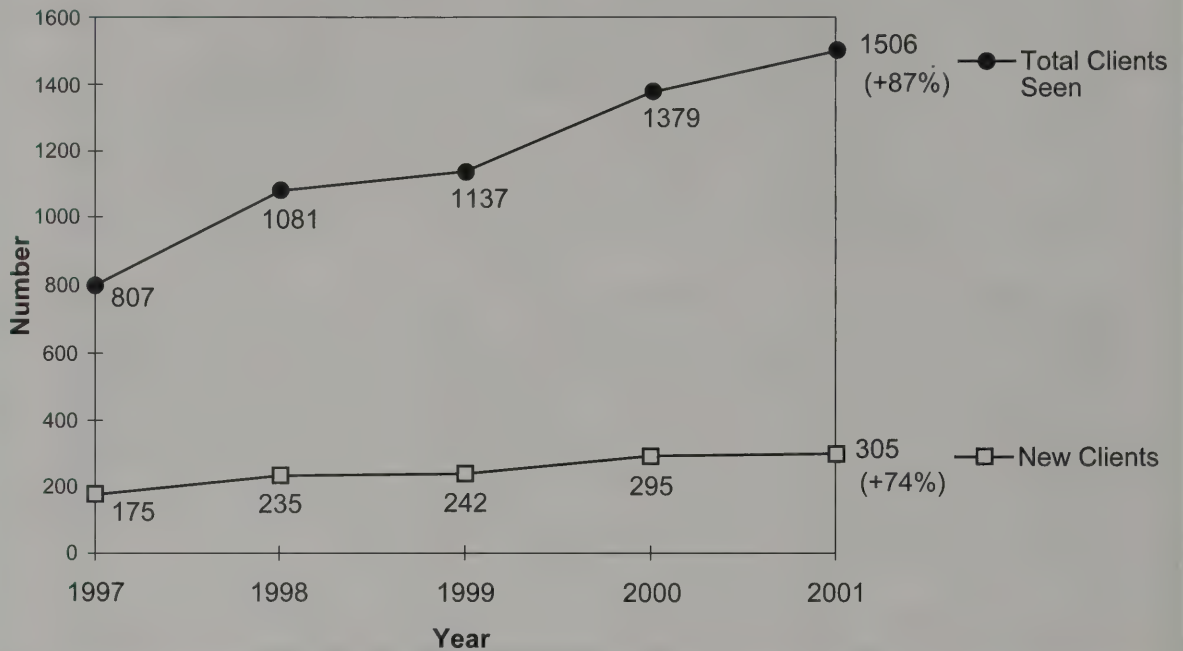
HIV and AIDS

Increased awareness is essential to promote the 'safer sex' message and reduce the transmission of HIV. In Britain in 2001, newly diagnosed HIV infection rose by 17% - the highest total of new cases for any single year.

In Guernsey there were 2 new cases of HIV during 2001, both presenting with an AIDS defining illness. This is similar to the UK experience where there has been an increased presentation of late stage HIV in patients with no previous diagnosis. This suggests that many young people believe that HIV no longer presents a risk. These false beliefs have been encouraged by media led stories of new HIV 'wonder drugs'. There is a real danger in believing that HIV can be successfully treated with new drugs. The new drugs undoubtedly play an important role in controlling symptomatic patients. However, there is no 'cure' as yet, and the disease is continuing to spread in both the homosexual and heterosexual communities. In Guernsey out of a total of 13 HIV cases, 3 were female.

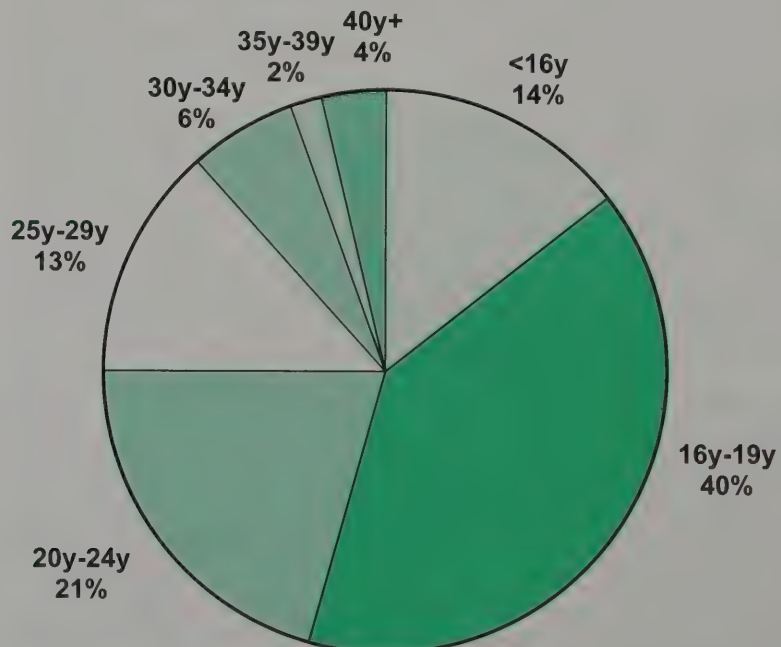


**Figure 5.1 - Guernsey Family Planning Clinic
New and Total Clients seen 1997-2001**



Source: Guernsey Family Planning Clinic

**Figure 5.2 - Guernsey Family Planning Clinic
New Clients by Age - 2001**



Source: Guernsey Family Planning Clinic

The new cases of hepatitis C are as a result of intravenous drug use and sharing of contaminated needles. Fortunately there has not been a similar increase in HIV in the drug using population which is more by luck than success of any needle exchange programme. HIV disease still presents a major challenge to public health in the emerging resource poor countries, where prioritising resource allocation has become an increasingly difficult. The prevalence of resistance to at least one anti-retroviral drug in newly infected patients has been reported in various studies as to be between 6% to 37%. This means that there is an increasing pool of resistant virus in the HIV infected population, which is spreading to newly infected patients. Prevention of transmission of HIV currently is the only way to control this disease. Greater emphasis and education of this essential message has to be made if we are to reduce the incidence of HIV infection and improve the sexual health for our community.

	First attendance	Subsequent attendance
Total attendances in the quarter- as on KH09 return	680	747
Incoming telephone calls for clinical advance or results	207	

Dr N C King
Sexual Health Clinic

Contraception Services *(figures 5.1, 5.2)*

The Guernsey Family Planning Clinic has enjoyed another busy year, with continuing upward trends - an increase of **3.4%** in new registrations and of **9.2%** in total clients seen during the past year. As well as becoming increasingly busy, it is pleasing to see greater access by those <20 years who now constitute **54%** of all new clients.

The Board of Health continue to give us support and is committed to seeing the clinic open every weekday. The funding is in place but getting the qualified staff is proving difficult.

The counsellor provides an excellent service for termination of pregnancy. Her figures this year were slightly down to **35** clients seen.

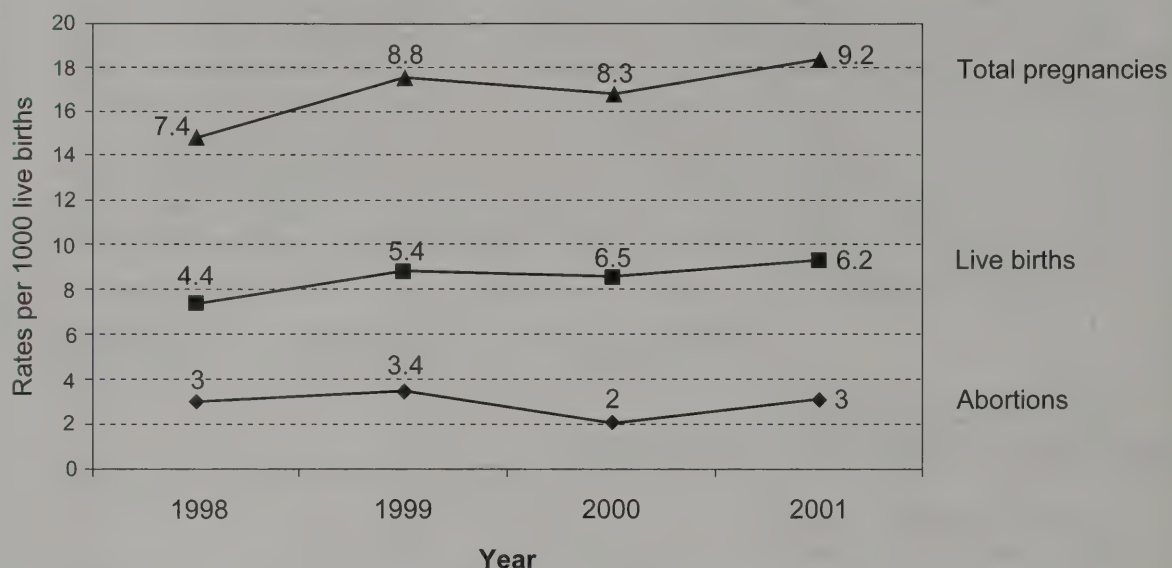
Interestingly, the figures for *Levonelle* have been steadily increasing over the last three years due to more publicity and better access.

We continue to work closely with the School Educators in promoting the Family Planning Clinic where any queries can be answered confidentially.

Mrs Sue Le Page
Manager

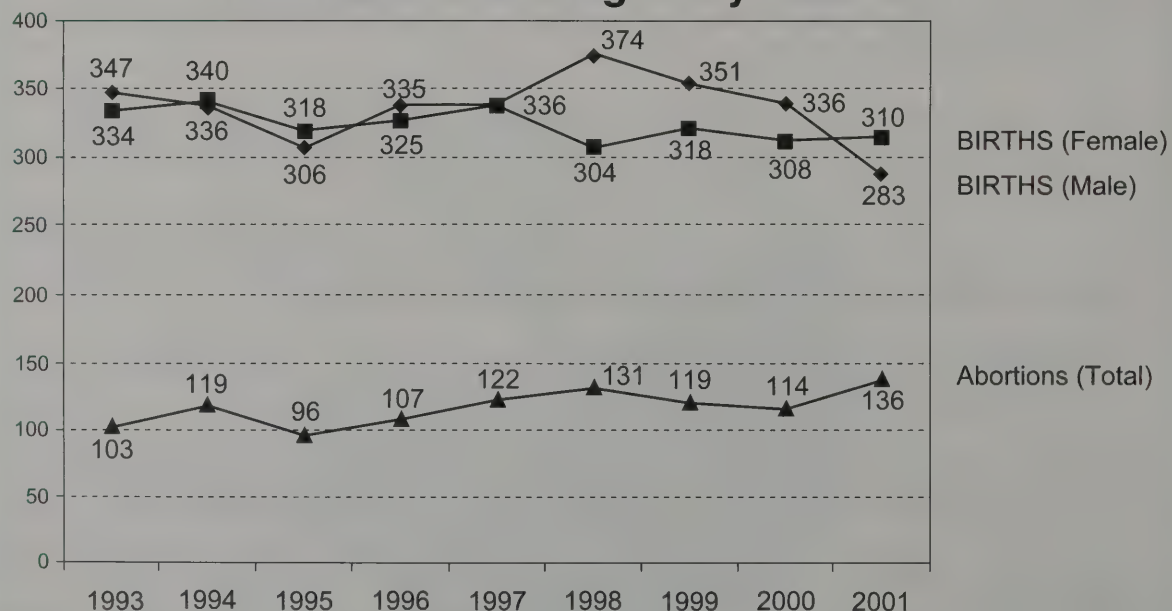


Figure 5.3 - Livebirths, abortions, total pregnancies to teenage girls Guernsey 1998-2001



Note (i) includes both abortions and live births for girls >20 years
(ii) abortions includes both spontaneous and medical abortions
Sources: Health Information Unit 2002

Figure 5.4 - Guernsey - Births and Terminations of Pregnancy 1993-2001



Teenage Pregnancies (figure 5.3)

In December 2001, the Department of Health in London launched a National *Strategy for sexual health and HIV*. The strategy pointed out that despite recent health advances there were an increasing number of people living with HIV, that rates of sexually transmitted diseases had increased significantly, and there was a high rate of unintended pregnancies. Of particular concern were teenage pregnancies. The *Strategy* stated;

‘England’s teenage birth rates are the highest in Western Europe - treble those in France and six times those in the Netherlands.’

In Guernsey too, there has been a concerning increase in ‘teenage’ conceptions with a **24%** increase in total pregnancies, and a **41%** increase in live births to local women <20 years of ages since **1998**.

During this period, abortion rates on local women <20 years have remained steady, suggesting that much of the increase in the birth rate in this age group may have been ‘wanted’ babies, or at least have been pregnancies in which abortion was not considered or not accepted. International comparisons suggest that countries such as France and Sweden, which have a low teenage birth rate, have a correspondingly higher teenage abortion rate.

Although the upward trend in conceptions <20 years in Guernsey is cause for concern, with **3.0** abortions, **6.2** live births and **9.2** total conceptions per 1,000 total live births, Guernsey has only **48%** of the terminations, **84%** of the live births and **68%** of the conceptions of teenage girls in England and Wales, where comparative figures are **6.2** abortions, **7.4** live births and **13.6** conceptions per 1,000 total live births.

Nonetheless, it re-emphasises the importance of maintaining effective sexual health education through school based programmes, ensuring that adequate sexual health information is available to those who have left schools, and continuing to maintain and develop our family planning, contraception and sexual health services.

Abortions (Figure 5.4)

During 2001, there were **136** lawful abortions performed on women normally resident in Guernsey. Of these **110** were performed in Guernsey and **26** in England and Wales.

Of those performed in Guernsey, **13** were to women under 20 years of age, and **11** to women over 35 years. For those performed in England and Wales **4** were to women under 20, and **2** to women over 35 years.

Overall, **22** abortions were performed on women who stated they were married, whilst in **4** cases marital status was not declared. With a crude abortion rate of **10.9** per 1,000 resident women aged 15-44 years, Guernsey has only **67%** of the abortion rate recorded in England and Wales - where rates are **16.2** per 1,000 resident women aged 15-44 years.

Although both the number of abortions and the proportion of abortions to live births in Guernsey is the highest for several years, a single years figures should not be interpreted as necessarily showing a trend.



Appendix 1

Guernsey and Alderney Vital Statistics 2001

- A1.1 Births and birth related data
- A1.2 Deaths and death related data
- A1.3 Guernsey deaths by ICD 10 codes and age groups 2001
- A1.4 Alderney vital statistics 2001

A1.1 Guernsey - Vital Statistics 2001

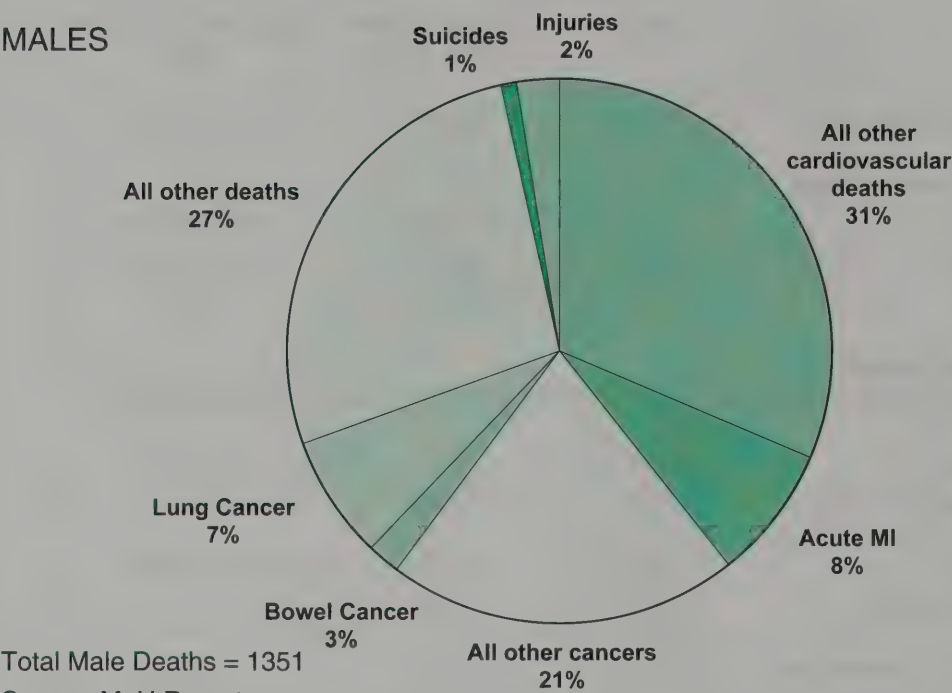
● Births and Birth-related Data

	Guernsey 2001	Guernsey 5 Year Mean 1994-1998	England & Wales 2001
Estimated Mid Year	59,807	58,867	52,943,000
Resident Population:			
• Males	29,138	28,297	26,142,000
• Females	30,669	30,570	26,801,000
• M : F	0.95	0.93	0.98
Population Density [Area 63.1Km²]:	948	933	51.8
Marriages:	303	345	263,500
• Marriages/000	5.1	5.9	5.0
Divorces:	187	165	144,600
• Divorces/000	3.1	2.8	2.7
Divorces : Marriages	0.62	0.48	0.55
Births:	593	662	594,360
• Males	283	337	304,489
• Females	310	323	289,871
• M : F	0.91	1.04	1.05
Births outside Marriage:	211	182	238,086
• % All Births	35.6%	28%	39.5%
Stillbirths:	4	4.2	3,159
• Rate/000 Live Births	6.7	6.3	5.3
Early Neonatal deaths: (0-6 days)	3	*	1,600
Late Neonatal deaths: (7-27 days)	0	2.2	1,246
Infant Deaths:(<1 year)	3	3	3,267
• Infant Death Rate/000	5.1	4.5	5.6
Crude Birth Rate/000	9.9	11.2	11.4
Natural Increase per annum:	0.6%	0.20%	0.13%

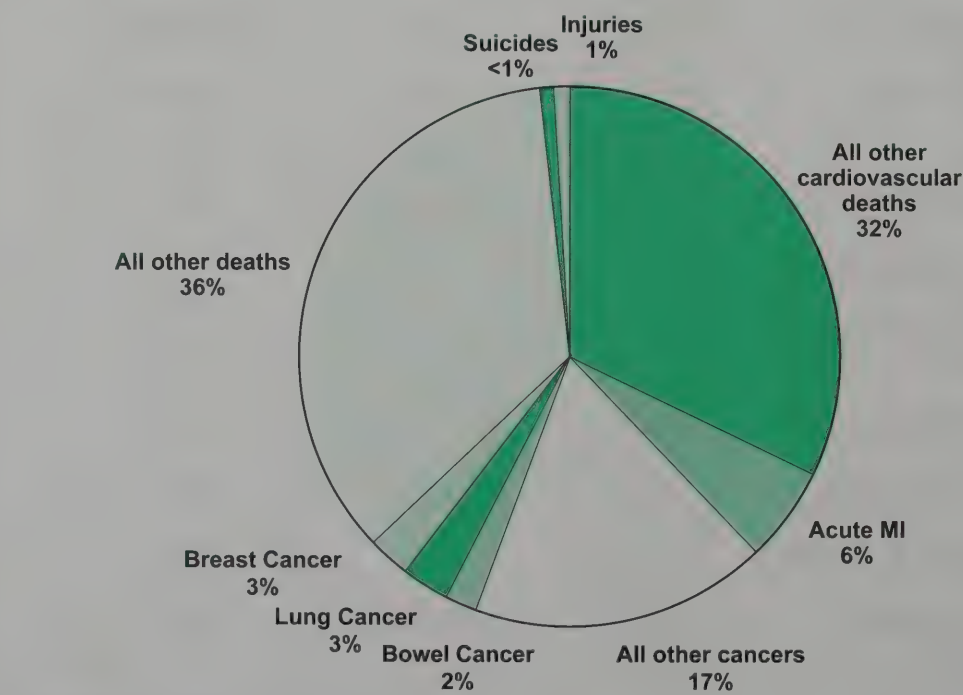


Deaths in Guernsey - By Cause 1997-2001

MALES



FEMALES



A1.2 Guernsey - Vital Statistics 2001

● Deaths and Death-related Data

	Guernsey		England & Wales
	2001	5 Year Mean 1994-1998	2001
Total Deaths:	560	592	535,600
• Males	290	289	255,500
• Females	270	305	280,100
• M : F	1.07	0.95	0.91
Crude Death Rate:/000	9.4	10.1	10.1
Circulatory Deaths (I00-I99):	206		266,720
• Males			
- Rate/00,000	374	406	359
• Females			
- Rate/00,000	316	388.6	218
Cancer Deaths (C00-C97/D00-D48):	120		138,313
• Males			
- Rate/00,000	240	298	243
• Females			
- Rate/00,000	163	261	167
Lung Cancer Deaths (C34):	26		30,199
• Males			
- Rate/00,000	65.2	79	64
• Females			
- Rate/00,000	22.8	38.6	30
Breast Cancer Deaths (C50):	10		11,759
• Females			
- Rate/00,000	32.6	42.5	43
Alcoholic Liver Disease (K70) (K74):	3		4,494
• Males			
- Rate/00,000	6.9	12.7	11
• Females			
- Rate/00,000	3.3	7.9	6.0
Injury Deaths (incl suicide) (S00-X59):	12		12,483
• Males			
- Rate/00,000	28	42	38
• Females			
- Rate/00,000	13	17.1	15
Suicide Deaths (X60-X84):	6		3,614
• Males			
- Rate/00,000	17	12.7	11.0
• Females			
- Rate/00,000	3.3	6.5	3.0



A1.3

GUERNSEY - DEATHS BY ICD 10 CODE AND AGE GROUPS - 2001

ICD10 Code No	Cause of Death	Total	Under 1		Age 1-14		Age 15-24		Age 25-44		Age 45-64		Age 65-74		Age 75+	
			M F		M F		M F		M F		M F		M F		M F	
			M	F	M	F	M	F	M	F	M	F	M	F	M	F
A16	Respiratory TB, not confirmed bacteriologically or histologically	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0
A41	Other Septicaemia	7	11	0	0	0	0	0	0	0	1	2	3	0	3	9
A46	Erysipelas	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Total Group I		8	12	0	0	0	0	0	0	0	1	2	3	0	4	10

Group II
Neoplasms

C02	Malignant neoplasm of other & unspecified parts of tongue	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0
C06	Malignant neoplasm of other and unspecified parts of mouth	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0
C15	Malignant neoplasm of oesophagus	5	3	0	0	0	0	0	0	0	3	0	1	0	1	3
C16	Malignant neoplasm of stomach	3	3	0	0	0	0	0	0	0	0	0	1	1	2	2
C18	Malignant neoplasm of colon	9	4	0	0	0	0	0	0	0	4	2	3	0	2	2
C19	Malignant neoplasm of rectosigmoid junction	1	1	0	0	0	0	0	0	0	1	0	0	1	0	0
C20	Carcinoma of the rectum	3	2	0	0	0	0	0	0	0	1	1	2	0	0	1
C22	Malignant neoplasm of liver & intrahepatic bile duct	3	0	0	0	0	0	0	0	0	1	0	1	0	1	0
C25	Malignant neoplasm of pancreas	5	2	0	0	0	0	0	0	0	1	0	2	1	2	1
C32	Malignant neoplasm of larynx	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0
C34	Malignant neoplasm of bronchus and lung	19	7	0	0	0	0	0	0	0	2	0	6	2	11	5
C43	Malignant melanoma of skin	0	1	0	0	0	0	0	0	1	0	0	0	0	0	0
C45	Mesothelioma	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0
C49	Malignant neoplasm of other connective and soft tissue	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0
C50	Malignant neoplasm of breast	0	10	0	0	0	0	0	0	3	0	3	0	1	0	3
C53	Malignant neoplasm of cervix uteri	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0
C56	Carcinoma of the ovary	0	2	0	0	0	0	0	0	0	1	0	0	0	0	1
C61	Carcinoma of the prostate	8	0	0	0	0	0	0	0	0	1	0	1	0	0	0
C66	Malignant neoplasm of ureter	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
C67	Malignant neoplasm of bladder	1	1	0	0	0	0	0	0	0	0	0	1	0	0	1
c/f		62	38	0	0	0	0	0	0	4	16	8	20	6	26	20

GUERNSEY - DEATHS BY ICD 10 CODE AND AGE GROUPS - 2001

A1.3

ICD10 Code No	Cause of Death	Total		Under 1		Age 1-14		Age 15-24		Age 25-44		Age 45-64		Age 65-74		Age 75+	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
		b/f															
C71	Malignant neoplasm of brain	62	38	0	0	0	0	0	0	0	0	16	8	20	6	26	20
C76	Malignant neoplasm of other and ill-defined sites	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
C77	Secondary & unspecified malignant neoplasm of lymph nodule	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
C79	Secondary malignant neoplasm of other sites	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
C80	Malignant neoplasm without specification of site	0	3	0	0	0	0	0	0	0	0	0	1	0	1	0	1
C82	Follicular non-Hodgkin's lymphoma	1	2	0	0	0	0	0	0	0	0	0	0	1	0	0	2
C83	Diffuse non-Hodgkin's lymphoma	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
C85	Other & specified types of non-Hodgkin's lymphoma	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
C90	Multiple myeloma and malignant plasma cell neoplasms	1	3	0	0	0	0	0	0	0	0	0	1	0	0	1	2
C91	Lymphoid leukaemia	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
C92	Myeloid leukaemia	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
	Total Group II	2	1	0	0	0	0	0	0	0	0	0	0	0	1	2	0
	Total Group III	70	50	0	0	0	0	0	0	1	4	16	11	22	8	31	27
Group III Diseases of blood & blood-forming organs & certain disorders involving the immune mechanism																	
D46	Myelodysplastic syndromes	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
	Total Group III	1	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0
Group V Mental and behavioural disorders																	
F03	Unspecified dementia	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1
	Total Group V	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Group VI Diseases of the nervous system																	
G11	Unspecified dementia	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
G12	Spinal muscular atrophy and related syndromes	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
G20	Parkinson's disease	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
G30	Alzheimer's disease	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
G80	Infantile cerebral palsy	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0
	Total Group VI	1	4	0	0	0	0	1	0	0	0	0	1	0	0	1	2



A1.3

GUERNSEY - DEATHS BY ICD 10 CODE AND AGE GROUPS - 2001

ICD10 Code No	Cause of Death	Group IX <u>Diseases of the circulatory system</u>															
		Total		Under 1		Age 1-14		Age 15-24		Age 25-44		Age 45-64		Age 65-74		Age 75+	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
I21	Acute myocardial infarction	26	17	0	0	0	0	0	0	0	0	5	1	5	5	16	11
I24	Other acute ischaemic heart disease	1	1	0	0	0	0	0	0	0	0	1	0	0	0	0	1
I25	Chronic ischaemic heart disease	11	8	0	0	0	0	0	0	0	0	0	0	2	1	9	7
I26	Pulmonary embolism	5	4	0	0	0	0	0	0	0	0	1	0	0	0	4	4
I27	Other pulmonary heart diseases	0	2	0	0	0	0	1	0	0	0	0	0	0	1	0	0
I35	Nonrheumatic aortic valve disorders	3	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0
I42	Cardiomyopathy	3	1	0	0	0	0	0	0	0	0	1	0	0	0	2	1
I46	Cardiac arrest	9	7	0	0	0	0	0	0	0	0	2	0	1	1	6	6
I48	Atrial fibrillation and flutter	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
I49	Other cardiac arrhythmias	2	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0
I50	Heart failure	21	22	0	0	0	0	0	0	0	0	4	1	6	3	11	18
I60	Subarachnoid haemorrhage	1	1	0	0	0	0	0	0	0	0	1	0	0	1	0	0
I61	Intracerebral haemorrhage	2	6	0	0	0	0	0	0	1	0	0	2	0	0	1	4
I62	Other nontraumatic intracranial haemorrhage	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
I63	Cerebral infarction	1	2	0	0	0	0	0	0	0	0	0	0	0	0	1	2
I64	Stroke (or cerebrovascular accident)	12	17	0	0	0	0	0	0	0	0	1	0	4	3	7	14
I66	Occlusion and stenosis of cerebral arteries, not resulting in cerebral infarction	1	4	0	0	0	0	0	0	0	0	0	0	0	1	1	3
I67	Other cerebrovascular diseases	1	2	0	0	0	0	0	0	0	0	0	0	0	0	1	2
I70	Arteriosclerosis	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
I71	Aortic aneurism and dissection	7	2	0	0	0	0	0	0	0	0	2	0	1	0	4	2
I73	Other peripheral vascular diseases	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1
Total Group IX		109	97	0	0	0	0	1	1	1	0	20	4	19	16	69	76

A1.3 GUERNSEY - DEATHS BY ICD 10 CODE AND AGE GROUPS - 2001

ICD10 Code No	Cause of Death	Total		Under 1		Age 1-14		Age 15-24		Age 25-44		Age 45-64		Age 65-74		Age 75+	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Group X																	
Diseases of the respiratory system																	
J13	Pneumonia due to Streptococcus pneumoniae	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
J17	Pneumonia in diseases classified elsewhere	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
J18	Pneumonia	50	46	0	0	0	0	0	0	0	1	4	4	2	45	40	
J44	Other chronic obstructive pulmonary disease	7	1	0	0	0	0	0	0	0	0	0	4	1	3	0	0
J81	Pulmonary oedema	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0
J84	Other interstitial pulmonary diseases	1	1	0	0	0	0	0	0	0	0	0	0	0	1	1	1
J96	Respiratory failure, not elsewhere classified	7	5	0	0	0	0	0	0	1	0	2	1	2	4	1	1
Total Group X		67	54	0	0	0	0	0	0	2	0	2	6	9	5	54	43
Group XI																	
Diseases of the digestive system																	
K55	Vascular disorders of intestine	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
K56	Paralytic ileus and intestinal obstruction without hernia	0	2	0	0	0	0	0	0	0	1	0	0	0	0	0	1
K57	Diverticular disease of intestine	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
K65	Peritonitis	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
K70	Alcoholic liver disease	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
K72	Hepatic failure, not elsewhere classified.	1	1	0	0	0	0	0	0	0	0	0	0	0	1	1	1
K74	Fibrosis and cirrhosis of liver	1	1	0	0	0	0	0	0	0	0	0	0	1	0	0	1
K76	Other diseases of liver	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0
K85	Acute pancreatitis	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0
K86	Other diseases of pancreas	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
K92	Other diseases of digestive system	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Total Group XI		4	13	0	0	0	0	0	0	1	1	0	0	1	1	2	11
Group XIV																	
Diseases of the genito-urinary system																	
N17	Acute renal failure	1	1	0	0	0	0	0	0	0	0	0	1	0	0	1	0
N18	Chronic renal failure	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
N19	Unspecified renal failure	4	4	0	0	0	0	0	0	0	0	1	0	2	0	1	4
Total Group XIV		6	5	0	0	0	0	0	0	0	0	1	1	3	0	2	4



A1.3 GUERNSEY - DEATHS BY ICD 10 CODE AND AGE GROUPS - 2001

ICD10 Code No	Cause of Death	Total		Under 1		Age 1-14		Age 15-24		Age 25-44		Age 45-64		Age 65-74		Age 75+	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
		<u>Group XVI</u> <u>Certain conditions originating in the perinatal period</u>															
P52	Intracranial nontraumatic haemorrhage of fetus & newborn	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
P95	Still-born	1	2	1	2	0	0	0	0	0	0	0	0	0	0	0	0
Totals Group XVI		2	2	2	2	0	0	0	0	0	0	0	0	0	0	0	0
<u>Group XVII</u> <u>Congenital malformations, deformations and chromosomal abnormalities</u>																	
Q92	Other trisomies and partial trisomies of the autosomes, not elsewhere classified	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0
Totals Group XVII		0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0
<u>Group XVIII</u> <u>Symptoms, signs & abnormal clinical & laboratory finding, not elsewhere classified</u>																	
R02	Gangrene, not elsewhere classified	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
R09	Other symptoms and signs involving the circulatory	2	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0
R50	Fever of unknown origin	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
R53	Malaise and fatigue	1	1	0	0	0	0	0	0	0	0	0	0	1	0	0	1
R54	Old age (senility)	7	22	0	0	0	0	0	0	0	0	0	0	0	0	7	22
R57	Shock, not elsewhere classified	1	4	0	0	0	0	0	0	0	0	0	0	1	0	1	3
R99	Other ill-defined and unspecified causes of mortality	3	1	1	0	0	0	0	0	0	0	1	1	1	1	0	0
Totals Group XVIII		15	29	1	0	0	0	0	0	0	0	1	2	3	0	10	27

GUERNSEY - DEATHS BY ICD 10 CODE AND AGE GROUPS - 2001

A1.3

ICD10 Code No	Cause of Death	Total		Under 1		Age 1-14		Age 15-24		Age 25-44		Age 45-64		Age 65-74		Age 75+	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Group XIX																	
Injury, poisoning & certain other consequences of external causes																	
T51	Toxic effect of alcohol	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
Total Groups XIX		0	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0
Group XX																	
External causes, morbidity & mortality																	
V23	Motorcycle rider injured in collision with car, pick-up truck or van	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
W19	Unspecified fall	1	1	0	0	0	0	0	0	1	0	0	0	0	0	0	1
W70	Drowning and submersion following fall into natural water	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
X08	Exposure to other specified smoke, fire and flames	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
X60	Intentional self-poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics	1	1	0	0	0	0	0	0	0	1	1	0	0	0	0	0
X67	Intentional self-poisoning by and exposure to other gases and vapours	2	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0
X70	Intentional self-harm by hanging, strangulation and suffocation	2	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0
Totals Group XX		8	3	0	0	1	0	1	0	4	1	1	1	0	0	1	1
Total Deaths:		292	272	3	3	1	0	1	2	9	6	42	29	61	30	175	202



6.4 Alderney Vital Statistics - 2001

	Males	Females	Total 2001	Total 2000
Population (2001 Census):	1,137	1,157	2,294	2,141
• M : F			0.98	0.92
Births - In Guernsey:	4	6	10	15
Births - In Alderney:	0	0	0	0
Total Births to Alderney residents:	4	6	10	15
Births outside marriage:	2	3	5	8
Crude Birth Rate/000	-	-	4.4	7.0
Marriages registered in Alderney:			8	9
Deaths registered in Alderney:	12	5	17	29
Crude Death Rate/000			7.4	13.5
Natural Increase:*			-7 [-0.3%]	-14 [-0.7%]

*The natural increase is the difference between the crude birth rate and the death rates expressed as a percentage of the resident population.

2.1 Staff providing public health services 2001

Director of Public Health/Medical Officer of Health

Dr David Jeffs MRCP MFPHM FAFPHM FRACGP FRSH

Personal Assistant

Miss Corinne Joy (*until July 2001*)

Ms Finuala Rowe (*until January 2002*)

Mrs Yvonne Kaill (*from January 2002*)

Part-time Medical Staff:

Deputy Medical Officer of Health

Dr Brian Parkin MB BS BSc MRCP MRCGP DRCOG

Sexual Health Clinic

Dr Nicholas King LRCP MRCS MBBS

Environmental Health Department:

Chief Environmental Health Officer

Mr John Cook MCIEH

Deputy Chief Environmental Health Officer

Mr Tony Rowe MCIEH

Environmental Health Officers

Mr Stan Horton MCIEH

Mr Stuart Wiltshire MCIEH

Mr Jonathon Coyde MCIEH

Mr Tobin Cook MSc MCIEH

Ms Isobelle Belcher BSc MCIEH PGCE (*until July 2001*)

Mrs Mhairi Macgregor BSc (Hons) (*from February 2001*)

Waste Regulation Officer

Mr Simon Welch BSc MInstWM

Pest Control Operatives

Mr Paul Tostevin

Mr Michael Brache

Secretary

Miss Kelly Moore (*until December 2001*)

Mrs Marilyn Bougourd (*acting since October 2001*)



Health Promotion Unit:

Health Promotion Officer

Miss Yvonne Le Page BEd(Hons) DipHE&HP RHPS

Assistant Health Promotion Officer

Mrs Gerry Grange RGN LAY Trainer RHPS

Resources Officer

Mrs Stephanie Charwood

Secretary

Mrs Pam Marsh (*until May 2001*)

Mrs Bella Mahy (*from September 2001*)

Health Strategy Unit:

Clinical Risk Manager

Mrs Jean Ellyatt RGN, SCM, CMS, Cert MHS

Clinical Audit Nurse

Miss Morag Fitzpatrick RGN, Dip He

Healthcare Information Manager

Mrs Allyson Huntingdon

Healthcare Information Officer

Mrs Helen Jones BSc (Hons) (*until August 2002*)

Health databases

Mrs Jenny Elliott

Clinical Coders:

Senior Clinical Coder

Mrs Margaret Cann

Clinical Coder

Mrs Sue Sheppard

